| DETOX HEALTH STATUS | ANALYSIS FORM |
|---|--|
| Name: | Date: |
| Street Address: | |
| City: | |
| Email Address: | |
| Age Date of birth: | |
| Occupation: | |
| What are your reasons for wanting to participate in the C | |
| 1 | 4 |
| 2 | |
| 3 | 6 |
| WOMEN - Is there any chance you could be pregnant? ☐ I am taking birth control pills ☐ Beginning Menop | |
| C U R R E N T H E A L T H H I S | TORY |
| Please list your current and past diagnoses (if any): | |
| | |
| Please list all current medications including dosages: | |
| List all OTC (over-the-counter medications) you take on | a regular basis (3 – 7 days a week): |
| | <i>z</i> · · <i>z</i> / <u></u> |
| List all of the vitamins, minerals and herbs you take alon | g with the daily dosages: |
| | |
| NUTRITION HEALTH H | |
| Do you have food allergies, restrictions, or sensitivities? | □ No □ Yes If yes, please explain: |
| *Are you allergic or intolerant to naturally occurring SU | |
| Describe your typical breakfast: | |
| Describe your typical lunch: Describe your typical dinner: | |
| Describe your typical snack(s): | |
| List the foods you crave: | |
| When you are thirsty, what do you drink? | |
| | |
| E X P O S U R E T O T O X I N S Have you at any time in your life or do you now live/wor □ Excess fluoride (fluoridated water, drops or treatment □ Excess mercury (paints, pesticides, art supplies etc) □ Environmental toxins (benzene, pesticides, molds, for | Excess exhaust fumes Excess lead (paint, paint chips etc) |

| W E I G H T H I S T O R Y Are you content with your current weight? Yes No If no, what is your ideal weight? | |
|---|--|
| CARDIOVASCULAR HEALTH HISTORY | |
| High blood pressure: ☐ No ☐ Yes High total cholesterol: ☐ No ☐ Yes High LDL: ☐ No ☐ Yes High triglycerides: ☐ No ☐ Yes High Chol/HDL Ratio: ☐ No ☐ Yes Low HDL: ☐ No ☐ Yes | |
| E N D O C R I N E H E A L T H H I S T O R Y Fatigue: No Yes Heat or cold intolerance: No Yes High blood sugar: No Yes Autoimmune disorder: No Yes Thyroid condition: Thyroid co | |
| SOCIAL, LIFESTYLE & EXERCISE HISTORY | |
| Do you consume alcohol? No Yes If so, how many drinks per day? Do you consume caffeine? No Yes If so, what type and how much per day Do you smoke/use tobacco? No Yes If so, what type and how much per day | |
| How many days per week do you exercise? | |
| STRESS AND SLEEP HISTORY | |
| On a scale from 1 – 10 rate your daily energy level? (1 being NO energy – 10 being VERY energetic) | |
| On a scale from 1 – 10 rate your daily stress level? (1 being NO stress – 10 being EXTREMELY stressed) | |
| What is the source of your stress: Job Financial Family/Relationship Other | |
| How many hours per night do you sleep? What keeps you awake? | |
| Do you have problems falling asleep? ☐ No ☐ Yes Do you have problems staying asleep? ☐ No ☐ Yes | |
| GASTROINTESTINAL HEALTH HISTORY | |
| Number of bowel movements per day? If not daily, then how often? | |
| Do you tend towards constipation? \square No \square Yes Are your stools loose on a regular basis? \square No \square Yes | |
| Have you had recent changes in your bowel habits? ☐ No ☐ Yes If yes, for how long? | |
| Abdominal pain/upset stomach: ☐ No ☐ Yes Gas/bloating: ☐ No ☐ Yes | |
| Heartburn/Reflux: ☐ No ☐ Yes | |
| Have you had a colonoscopy? No Yes If yes, what were the results? | |
| I understand that Loryn Galardi, M.S. is a clinical nutritionist and does not dispense medical advice nor prescribe treatment. Rather, she provides education to enhance my knowledge of health as it relates to foods, dietary supplements, and behaviors associated with eating. While nutritional and botanical support can be an important compliment to my medical care, I understand nutrition counseling is not a substitute for the diagnosis, treatment, or care of disease by a medical provider. I acknowledge that my physician is my primary health care provider, and is responsible for supervising all changes in diet, nutrient intake and exercise. I understand that Loryn Galardi, M.S. will keep therapy notes as a record of our work together. These notes document the topics that we talk about, interventions used, and treatment plan or any other considerations that may be helpful to your work with me. Records will be stored in a secure location. Medical records, personal information and history divulged in session to Loryn Galardi, M.S. will be kept strictly confidential unless I consent to sharing my medical and nutritional information by way of a signed release. I agree to hold Loryn Galardi, M.S. harmless for claims or damages in connection with our work together. This is a contract between myself and Loryn Galardi, M.S., and I understand that it is also a release of potential liability. | |
| The above information is true to the best of my knowledge. | |
| Signed: Date: | |