Champion Chiropractic and Wellness Center, Inc. Nutrition Intake Form

Lexi Sandifer, NTP
2405 Evergreen Park Dr. SW #B1
Office: 360.438.6559 Fax: 360.352.4202

Date_____

Parent/Guardian Contact Information:

Parent Name:_____
Last Name First Name Initial

Street Address_____ City_____Zip_____

Home Phone( )_____ Cell ( )_____
Work Phone( )_____ Email_____

Age_____ Date of Birth_____ Sex ☐M ☐F ☐Married ☐Single ☐Widowed ☐Separated ☐Divorced

Driver's License_____ Social Security Number_____

Who May We Thank For Referring You_____

Child's Information:

Child _____
Last Name First Name Initial

Street Address_____ City_____Zip_____

Age_____ Date of Birth_____ Sex ☐M ☐F

Name of Family Doctor_____

Person to contact in case of emergency_____ Phone Number_____

☑Please give this page to the receptionist before completing the rest of the packet

Please explain the reason for this visit_____

When did it begin?_____ Is it getting worse? ☐Yes ☐No ☐Constant ☐Comes and Goes

Is this condition interfering with ☐school ☐sleep ☐daily routine (check all that apply)

Has the child had this or similar conditions in the past? ☐Yes ☐No If so, explain_____

Has the child been treated by another professional for this condition? ☐Yes ☐No If yes, where_____

If you could wave a magic wand, what would you like to see improved?_____

_____

List any past accidents, injuries and hospitalizations, the date of occurrence, including infancy/childhood.

_____ _____

_____ _____

_____ _____

Please list any and all *medications*, including over- the- counter, that the child is currently taking and the dose:

Medication	Date Started Taking	For	Dose

Please list any and all *supplements*, the brand of the supplement, and how many currently taking:

Supplement	Brand	Date Started Taking	Dose

Have you or your family recently experience any major life crisis or changes in the past year? ☐Yes ☐No
If so, please comment:
How many days has the child been unable to attend school or social functions in the past year due to illness? ☐0-2 days ☐3-14 days ☐15+days

What are the child's allergies? Including household cleaners, latex, food, medications, iodine, etc? Please list all.

_____

_____

_____

How often has the child taken oral steroids (Cortisone, Prednisone etc.)?

Infancy/Childhood_____

Teen_____

How often has the child taken antibiotics?

Infancy/Childhood_____

Teen_____

Childhood (0-12):
Was the child a full term baby? ☐Yes ☐No ☐Premature ☐Don't Know
As an infant was/is the child ☐breast fed ☐bottle fed ☐ Don't Know
Does the child consume a lot of sugar/candy ☐Yes ☐No ☐Don't Know
Does the child consume a lot of pop/soda ☐Yes ☐No ☐Don't Know

As a Teen (13-18)
Does the teen consume a lot of sugar/candy ☐Yes ☐No ☐Don't Know
Does the teen consume a lot of pop/soda ☐Yes ☐No ☐Don't Know
Does the teen consume a lot of coffee or coffee drinks ☐Yes ☐No ☐Don't Know
Does the teen consume Energy Drinks or Gatorade ☐Yes ☐No ☐Don't Know

Does the child consume sugar substitutes (aspartame, sweet and low, splenda etc.)☐Yes ☐No ☐On Occasion

Does the child feel worse at certain times of the year? ☐Yes ☐No
If yes, is it during ☐Spring ☐Summer ☐Winter ☐Fall

Does the child have dental implants or mercury/amalgam fillings, caps or crowns? ☐Yes ☐No

Please check any of the following that apply to the child.

☐Abuse (Verbal, Physical, Mental) ☐ADD/ADHD ☐Anemic ☐Anxiety
☐Artificial Bones/Joints ☐Arthritis ☐Asthma ☐Autistic
☐Bedwetting ☐Behavior Issues
☐Bronchitis ☐Bi Polar Disorder ☐Cancer_____ ☐Chemotherapy
☐Chronic Fatigue Syndrome ☐Crohn's Disease ☐Chronic Runny Nose ☐Chronic Sore Throat
☐Congenital Heart Defect ☐Constipation ☐Dermatitis (skin rash) ☐Depression
☐Diabetes 1 ☐Diabetes 2 ☐Diarrhea
☐Ear Infections ☐Tubes In Ears ☐Hearing Difficulties ☐H Pylori
☐Epilepsy ☐Fibromyalgia ☐Frequent Colds
☐Gallstones ☐Gallbladder Removed ☐Gastric Reflux
☐Heart Attack ☐Heart Failure ☐Heart Murmur ☐Heart Problems
☐Hepatitis ☐HIV/Aids ☐High Cholesterol ☐High Triglycerides
☐High Blood Pressure ☐Hives ☐Hyper Thyroid ☐Hypo Thyroid
☐ Incontinence (Day) ☐Irritable Bowel ☐Kidney Stones ☐Low Blood Pressure
☐Mumps ☐Molestation ☐Mononucleosis ☐Pneumonia
☐Rape ☐Rheumatic Fever ☐Seizures ☐ Sensory Integration Disorder
☐Sinusitis ☐Snore ☐Strep Throat
☐Temperature Regulation Issues ☐Thrush
☐Ulcer ☐Yeast Infections
☐Other: _____

Please check any of the following symptoms that apply to you

☐Finger Tips Turn White ☐Always Cold ☐Gas/Colic/Cramping ☐Rash On Face or Body
☐Fatigue ☐Diarrhea ☐Bloated
☐Difficulty swallowing ☐Burping ☐Sneezing/Allergies ☐Red Bumps -Arms/Chest/Legs
☐Headaches ☐Migraines ☐Fainting ☐Cough a lot
☐Difficulty Breathing ☐Insomnia ☐Hair Loss ☐ClearsThroat Frequently

Does your child have a bowel movement (poop) ☐More than 3 times per day ☐1-3 times per day ☐4-6 times per week ☐2-3 times per week ☐1 or less times per week

Does the child's poop ☐float ☐have oil present ☐pellet like ☐watery ☐loose ☐light in color ☐green in color ☐dark in color

Is the child on a special dietary program? ☐Yes ☐No (Including Vegetarian)
If yes please describe_____

Does the child exercise? ☐Yes ☐No If yes, what do you do for exercise and how often?_____

Is the child on a specialized diet (GAPs, Vegan, etc.) Yes No If yes please explain:_____
_____

PRENATAL HISTORY:

Were there any complications during the pregnancy (trauma, emotional stress, high blood pressure, diabetes, bleeding, toxemia, hospitalizations, medications taken)? Please explain_____

_____

How was the labor and delivery? Were there any interventions (i.e. forceps, vacuum C- section)_____

_____

Was your child born: ☐Pre - term ☐Term ☐Post - Term

☐Child's weight at birth _____ Child's length at birth _____
How were your child's APGAR scores at birth, if known? _____
Was your child breastfed ☐Yes ☐No If Yes, for how long?_____
If No, what formula was your child given? _____
Was your child healthy during the neonatal period ☐Yes ☐No If No, please explain _____

_____

At what age was solid food introduced and what was the child fed?_____

_____

SOCIAL HISTORY:

Does your child attend daycare or school? ☐Yes ☐No If Yes, what grade/level are they in? _____

How is your child's social and academic performance (both in school and at home)? _____

_____

Is your child involved in any extra-curricular activities, sports, hobbies? ☐Yes ☐No
If yes, please explain: _____

What does your child enjoy doing in his/her spare time? _____

Does your child get exercise? ☐Yes ☐No How often/What type?_____

How much sleep does your child get, on average? _____

Does your child wake through the night? ☐Yes ☐No Nightmares? ☐Yes ☐No

If you could wave a magic wand, what would you love to see improved most in your child?_____

_____

-Girls Only- (menstruating)

How old were you when you started your period?_____ Did you have difficult periods?____
Do you suffer from PMS?_____
Have you been diagnosed with endometriosis?_____
Do you experience rage, anger, weepy or other mood swings?_____

Do you have food cravings? _____If yes, what are they and when do they occur?_____

Do you get painful breasts?_____
Do you suffer from depression with your cycle?_____
Do you have heavy vaginal discharge?_____
Do you get yeast infections?_____
Do you have acne?_____
Do you get fatigued easily?_____
Do you get hot flashes?_____
Do you have heavy periods?_____
Do you have problems with anxiety or nervousness?_____
Do you have a problem concentrating?_____
Do you have difficulty maintaining your weight?_____
Do you have swelling or edema?_____
Do you have sleep difficulty?_____
Do you have dry skin?_____
Do you have an eating disorder Anorexia, Bulimina etc?_____
Do you do something to cause harm to yourself? (cut, drugs, etc.)_____

Have you had your thyroid levels checked within the last 6 months?_____
Have you had your hormone levels checked within the last 6 months?_____
Have you had mental health counseling in your lifetime?_____

-Boys Only- (age 12+)

Do you have dry skin? ☐Yes ☐No
Do you have difficulty sleeping? ☐Yes ☐NO
Do you have problems concentrating? ☐Yes ☐NO
Do you have breast development? ☐Yes ☐NO
Do you take recreational drugs? ☐Yes ☐No
Do you use alcohol to deal with life stress? ☐Yes ☐No
Do you have a loss of muscle mass? ☐Yes ☐No
Do you have low energy? ☐Yes ☐No
Do you avoid activity? ☐Yes ☐No
Do you have restless legs at night? ☐Yes ☐No
Do you have difficulties focusing/paying attention? ☐Yes ☐No
Do you have body aches and pains? ☐Yes ☐No
Do you get headaches? ☐Yes ☐No
Do you get chest pain? ☐Yes ☐No
Have you gained weight in the last year? ☐Yes ☐No
Do you have a loss of interest in life? ☐Yes ☐No
Do you have night time urination? ☐Yes ☐No How Many Times Per Night_____
Do you have emotional management problems? (Rage) ☐Yes ☐No
Do you have breast development? ☐Yes ☐No
Do you have swelling or edema in your legs or hands? ☐Yes ☐No
Have you had your hormone levels checked within the last 6 months? ☐Yes ☐No
Have you had your thyroid levels checked within the last 6 months? ☐Yes ☐No
Have you had mental health counseling in your lifetime? ☐Yes ☐No

NUTRITIONAL THERAPY INFORMED CONSENT WAIVER AND DISCLAIMER

Alexia Sandifer, Nutritional Therapist of Champion Chiropractic Center, Inc.

Before you choose to use the services of a Nutritional Therapist, please read the following information FULLY AND CAREFULLY.

GOAL: The basic goal of an NT is to encourage people to become knowledgeable about and responsible for their own health, and to bring it to a personal optimal level. Nutritional Therapy is designed to improve your health, but is not designed to treat any specific disease or medical condition. Reaching the point of optimum health, absent other nonnutritional complicating factors, requires a sincere commitment from you, possible lifestyle changes, and a positive attitude. A nutritional therapist is trained to evaluate your nutritional needs and make recommendations of dietary change and nutritional supplements. We do NOT provide medical diagnoses,and no comment or recommendation should be construed as such. Since every human being is unique and has their own biochemistry, we cannot guarantee any specific result from our programs.

HEALTH CONCERNS: If you suffer from a medical or pathological condition, you will need to consult your appropriate healthcare provider. A Nutritional Therapist is not a substitute for your family physician or specialist. It is not to be used in lieu of medical needs. We are not trained nor licensed to diagnose, treat pathological conditions, illnesses injuries, or diseases.
If you are under the care of a physician, it is important to contact them and let them know you are taking nutritional supplements. Nutritional Therapy may be a beneficial adjunct to more traditional care, and it may also alter your need for medication, so it is important that you always keep your physician informed of changes in your nutritional program. If you are using medications of any kind, you are required to alert the Nutritional Therapist to such use, as well as to discuss any potential interactions between medications and nutritional products with your pharmacist. However, healing reactions are very normal when correct changes occur to the body.

COMMUNICATON: Every client is an individual, and it is not possible to determine in advance how your system will react to the supplements you need.
If you choose to use supplementation, it is sometimes necessary to adjust your program as we proceed until your body can begin to properly accept products geared to correct the imbalance. It is your responsibility to follow nutritional guidelines and recommendations, exercise your body and mind to stay in positive balance, eat a proper diet, get plenty of rest and stay abreast of nutrition. You must stay in contact with your nutritional therapist so that the correct course of action can be taken.

You should request your other healthcare provider, if any, to feel free to contact me at 360-438-6559 to address any questions they may have regarding nutritional therapy.

LICENSURE. A Nutritional Therapist is not licensed or certified by any state. However, a Certified NT is trained by the Nutritional Therapy Association, Inc. which provides a certification of completion to the program to students who have successfully met all course requirements, including a written and practical exam. A license to practice NutritionalTherapy is not required in some states. Laws and regulations regarding certification and licensure requirements differ from state to state.

_____ _____

Signature Date

_____

Printed Name

Clinical Nutrition At The Cellular Level
Lexi Sandifer, N.T.P.

I, _____ hereby give Alexia Sandifer, N.T.P. permission to treat my child (children)

_____

_____

_____

_____

_____

_____

_____

By my signature below, I hereby authorize and consent my child to receive nutritional therapy treatment by Lexi Sandifer N.T.P. of Champion Chiropractic and Wellness Center. A photocopy of this authorization shall be considered valid as the original

Parent Signature_____Date_____
Witness_____Date_____

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