ACHIEVING HEALTH THRU NUTRITION, LLC

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CLIENT REGISTRATION
Client Information: PLEASE PRINT LEGIBLY

MS, MRS., MISS, MR., DR. (CIRCLE ONE)

Last Name____ First Name___________________________ Middle Int. ____

Mailing Address: ____

City_____________________ State: __________ Zip Code: ___________

Sex:___________________________ Marital Status: ___________________

Home Phone: (___) ___________________________ Work Phone: ( )__________________________

Cell Phone: ( ) ______________________________

Home Fax: ( ) _________ ______________________ Office Fax: ( )________________________________

Other Fax: ( ) _____________________________

Special Instructions for faxing: Does it need a cover sheet? Yes______________ No __ Do we need to call before faxing? Yes

____ No __

Send Fax c/o: ____ Other ______________________________

Providing a FAX NUMBER IS VERY IMPORTANT when working with us if you want to do phone consultations. If you do not have a fax at home or your office, try a friend, spouse, or neighbor. Otherwise, try your local drug store or copy center.

Date of Birth: _________________ Social Security #: ___________________ Employer: ______________________________

Email Address ____

IN CASE OF EMERGENCY, PLEASE NOTIFY:

Name:____ Relationship:_______________________

Telephone Numbers: Home: _____________________________ Work: ____________________

Other:____________________

My primary care physician is:______________________________________Telephone number:______________________

CLIENT REGISTRATION (continued)

How did you hear about Achieving Health Thru Nutrition, LLC? ____

DID A PHYSICIAN REFER YOU TO OUR PRACTICE?____

Physician's Full Name: ________________________________Phone: (   )_______________Fax: ( )____________

RESPONSIBLE PARTY INFORMATION: Please complete any information different from client information.

(circle one) (First) (Middle) __ (Last)

MS., MRS. , MISS, MR. ,DR. Name: ____

Address: ____________________________________ City:____________ State_____ Zip Code:___________

Relationship to the Client:

Spouse_______________ Parent/Guardian_______________ Other:

Home Phone: (   )____________________ Work Phone: (   ) ______________ Fax:(   )______________

SIGNATURE:___________________________________ Date:___________________________

OPTIONAL - If you wish to leave a credit card number on file to speed check-out, particularly after telephone consultations .

Please complete the following section.

I authorize Trudy Ekstrom, Ph.D. of Achieving Health Thru Nutrition, LLC to debit my credit card listed below for any charges incurred by me or others for whom I authorize charges.

Credit Card Number: _______________________________ Expiration Date: _________

VISA_______ MC ________

I authorize charges to my account for:

Myself ___ Spouse ____(Name: _____________________________)

Dependent ____ (Name:____________________________________)

Printed Name on Card:_________________________________ _________________________

Cardholders Signature:

____

Amino Acid Therapy Chart: Reversing Neurotransmitter Depletion

Name **Date**

(1) In Column A, put a number from 1 to 10 by each symptom you feel, with 1 being slightly felt or hardly ever felt and 10 being strongly felt or felt all the time.
(2) Check the Column B substances that you use to reduce the symptoms in the same section of A.

Column A **NT Deficiency Symptoms**	**Column B** **Substances Used**
Type 1 Low in Serotonin _____ negativity, depression _____worry, anxiety _____low self-esteem _____obsessive thoughts or behaviors _____winter blues * _____ PMS _____ irritability, rage _____ dislike hot weather _____ panic attacks: phobias (fear of heights, small spaces, snakes, etc.) _____ afternoon or evening cravings _____ fibromyalgia, TMJ, _____ suicidal thoughts _____ night owl, hard to get to sleep _____ insomnia, disturbed sleep Typical sleep hours __________to _______	☐ sweets ☐ starch ☐ tobacco ☐ chocolate ☐ Ecstasy ☐ marijuana ☐ alcohol ☐ Prozac ☐ Zoloft ☐ Paxil ☐ Effexor ☐ Celexa ☐ other
Type 2 Low in Catecholamines ____ depression ____ lack of energy ____ lack of drive ____ easily bored ____ lack of focus, concentration ____ ADD	☐ sweets ☐ starch ☐ chocolate ☐ aspartame ☐ alcohol ☐ marijuana ☐ caffeine ☐ cocaine ☐ speed ☐ tobacco ☐ Wellbutrin ☐ Ritalin ☐ Adderol

Type 3 Low in GABA	
_____ stiff and tense muscles _____ stressed and burned out _____ unable to relax/loosen up _____ often feel easily overwhelmed	☐ sweets ☐ starch ☐ tobacco ☐ marijuana ☐ alcohol ☐ Valium ☐ Ativan ☐ Neurontin ☐ other
Type 4 Low in Endorphin	
_____ very sensitive to emotional or physical pain _____ cry (tear up) easily _____ crave comfort, reward, or numbing treats _____ "love " certain foods, behaviors, drugs or alcohol	☐ sweets ☐ starch ☐ chocolate ☐ tobacco ☐ marijuana ☐ alcohol ☐ caffeine ☐ Vicoden ☐ heroin ☐ other
Type 5 Hypoglycemic	
_____ cravings for sugar, starch, or alcohol _____ irritable, shaky, especially if its too long between meals	☐ sweets ☐ starches ☐ alcohol

*Also test for vitamin D levels (250HD) optimal reference 35-70. Moderate exercise as tolerated. 2500-10,000 lux light box – preferably at least partly full-spectrum, with UV protection.

3 DAY DIET RECALL

DAY1	DAY 2	DAY 3
BREAKFAST	BREAKFAST	BREAKFAST
MID-MORNING SNACK	MID-MORNING SNACK	MID-MORNING SNACK
LUNCH	LUNCH	LUNCH
AFTERNOON SNACK	AFTERNOON SNACK	AFTERNOON SNACK
DINNER	DINNER	DINNER
AFTER DINNER SNACK	AFTER DINNER SNACK	AFTER DINNER SNACK

Please note time and any activity while eating. Be sure to include any beverages.

Do you smoke? ☐ Yes ☐ No Drink alcohol? ☐ Yes ☐ No
How much/when? ________________ How much/when? ________________
Do you drink caffeine every morning? ☐ Yes ☐ No
Do you ever overeat? ☐ Yes ☐ No If so, which foods and how often?
____
Describe your daily energy levels ______________________________
Do you get noticeably irritable, light-headed or weak if you haven't eaten in a while? ☐ Yes ☐ No
Do you crave any of the following?

☐ Sugar ☐ Meat fat ☐ Chocolate ☐ Fish ☐ Alcohol
☐ Desserts ☐ Milk ☐ Bread ☐ Fried Food ☐ Other __________

Do you take any nutritional supplements or vitamins? ☐ Yes ☐ No If so, which ones (Be specific. Attach another sheet if necessary)________________
____
____
____
Which prescription and over the counter medications do you take regularly?
____
____
____
Which oils do you use/consume?

☐ Butter ☐ Peanut Oil ☐ Canola Oil ☐ Margarine
☐ Corn Oil ☐ Sun/Safflower ☐ Olive Oil ☐ Crisco
☐ Mayonnaise ☐ Coconut Oil ☐ Vegetable Oil ☐ Flaxseed Oil
☐ Soybean Oil ☐ Other ________________

How is your dental health? ____
How many bowel movements do you have a day? ______________________
Rank your skin without lotion: ☐ Very dry ☐ Dry ☐ Normal ☐ Oily ☐ Combo
Please check off any of the following that pertain to you (past or present);

☐ Acne ☐ Addiction (alcohol, drugs) ☐ Anemia
☐ Anorexia ☐ Anxiety or Nervousness ☐ Arthritis (Rheumatoid/Osteo)
☐ Bladder Infections ☐ Bloating, Gas, or Indigestion ☐ Blood Sugar Problems
☐ Bronchitis ☐ Caner ☐ Colds or Flu (frequent)
☐ Cold Sores ☐ Chronic Fatigue ☐ Constipation
☐ Dandruff ☐ Depression ☐ Diabetes I (insulin depend)
☐ Diabetes II (adult onset) ☐ Diarrhea ☐ Difficulty Losing Weight
☐ Difficulty Gaining Weight ☐ Emotional Problems ☐ Emphysema
☐ Fainting ☐ Gall Bladder Problems ☐ Gout
☐ Hair Loss or Poor Growth ☐ Headaches ☐ Heart Disease or Problems
☐ Heartburn ☐ Hemorrhoids ☐ Herpes Simplex or Type II
☐ High Blood Pressure ☐ High Cholesterol ☐ HIV
☐ Hot Flashes ☐ Hypoglycemia ☐ Insomnia
☐ Intestinal Problems ☐ Kidney Stones ☐ Liver Problems
☐ Loose Stools ☐ Memory Loss or Confusion ☐ Nails, Poor Growth
☐ Panic Attacks ☐ Parasites ☐ Seizures
☐ Severe Mood Swings ☐ Skin Conditions ☐ Stroke
☐ Suicidal Tendencies ☐ Thyroid Condition ☐ Ulcer
☐ Yeast Infections

How did you hear about our practice? ________________________________

Have you ever had a serious reaction to a medicine or any other substance?

☐ Yes ☐ No If so, please explain.

____

____

Do you have any food sensitivities? ☐ Yes ☐ No ☐ Unknown If so, please explain. ____

____

____

Does your work or hobbies put you in contact with chemicals of an industrial nature (pesticides, herbicides, solvents, cleaners, dyes or paints, metals, dust, fumes)? ☐ Yes ☐ No If so, explain. ______________________________

____

____

Do you live or have you ever lived near power plants, factories or other sources of pollution? ☐ Yes ☐ No If so, explain. _________________________

____

____

List the most important issues regarding you health and what you expect or hope for in coming to Achieving Health Thru Nutrition, LLC.

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____
7. ____
8. ____

Please check all that pertain:

Women	Men
☐ PMS	☐ Frequent Urination
☐ Irregular Periods	☐ Difficulty Urination
☐ Painful Periods	☐ Loss of Libido
☐ Loss of Periods	☐ Prostate Enlargement
☐ Birth Control Pills	
☐ Menopause	
☐ Painful Intercourse	
☐ Children	
☐ Hysterectomy	

Please list any disease, illness, or ailments in your immediate family (mother-breast cancer, father-type II diabetic, grandfather-heart disease)

____

____

____

____

Do you exercise? ☐ Yes ☐ No If so, what kind?____________________

How often? ______________ Since When? ____________________

Rate the following:

Daily energy level	☐ Excellent	☐ Good	☐ Fair	☐ Poor
Energy level after exercise	☐ Excellent	☐ Good	☐ Fair	☐ Poor
Daily stress level	☐ Excellent	☐ Good	☐ Fair	☐ Poor
General enjoyment of life	☐ Excellent	☐ Good	☐ Fair	☐ Poor

How many hours do you sleep? _______ Do you sleep soundly? ☐ Yes ☐ No

Please describe any health concerns you think are important. ______________

____

____

____

Hospitalization or Surgery with the Dates

____

____

____

____

Women: Are you pregnant? ☐ Yes ☐ No

Are you planning to be pregnant? ☐ Yes ☐ No

By signing below, you acknowledge that any dietary or supplemental suggestions made by Trudy Ekstrom, Ph.D. and Achieving Health Thru Nutrition, LLC are entirely nutritional in nature, and are not intended as the diagnosis, cure or treatment for any disease or ailment. You also acknowledge that your physician is your primary health care provider.

Signature____________________________ Date ______________________