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|--|---|---|
| Nutritional Counseling<br>Food Sensitivity Testing<br>Neurotransmitter Testing<br>Hormone Testing<br>Wellness & Prevention | THE CHIROPRACTIC<br><b>wellnessconnection</b><br>111 O'Fallon Commons Drive<br>O'Fallon, MO 63368<br>Phone: 636-978-0970<br>Fax: 636-978-7570 | Dr. Olivia Joseph<br>Certified Clinical Nutritionist<br>Board Certified Acupuncturist<br>droivia@wellnessconnection-ofallon.com |
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**All nutrition appointments NOT given 24 hours notice of cancellation will incur a \$50 charge.**

**BEFORE SEEING DR. OLIVIA APPOINTMENT:**

**1st Appointment DATE:** \_\_\_\_\_ **TIME:** \_\_\_\_\_  
 30 minute evaluation

- \_\_\_ Fill out Nutrition Questionnaire
- \_\_\_ Fill out 3 day Food Log
- \_\_\_ Watch the Basic Nutrition video at [www.CookingWithOlivia.com](http://www.CookingWithOlivia.com) on the video page

**DURING YOUR FIRST APPOINTMENT A DISCUSSION OF THE FOLLOWING WILL OCCUR: [Cost \$125]**

- \_\_\_ Comprehensive Review of Nutritional & Health History.
- \_\_\_ Supplement protocol to immediately relieve your symptoms and current health problem(s).
- \_\_\_ Possible benefits and timing of a cleansing/detoxification program.
- \_\_\_ Possible benefits and timing of laboratory testing used to evaluate:  
*Food Allergies/Sensitivities---Hormone Imbalances---Stress Hormone Issues*
- \_\_\_ Lifestyle changes that you need and are willing to make.

**Follow Up Appointments (15 minutes):**

**2nd APPOINTMENT DATE:** \_\_\_\_\_  
**Before appointment watch the "Detoxification" Video at**  
[www.CookingWithOlivia.com](http://www.CookingWithOlivia.com)  
**- Bio-Impedance Analysis will be done on this visit to determine toxicity levels, hydration, mineral & essential fatty acid deficiency.**

**3rd APPOINTMENT DATE:** \_\_\_\_\_  
**Before appointment watch the "Do I need Vitamins?" video at**  
[www.CookingWithOlivia.com](http://www.CookingWithOlivia.com)

**4th APPOINTMENT DATE:** \_\_\_\_\_  
**Please fill out a new nutritional questionnaire and 3 day food log and turn in 24 hours prior to your final evaluation of the year.**

**Please bring to all appointments:**

- \_\_\_ This Folder
- \_\_\_ A copy of any recent diagnostic or laboratory testing
- \_\_\_ Any vitamins or supplements not recommended by Dr. Olivia or purchased at this office

**DURING YOUR FOLLOW UP APPOINTMENTS THE FOLLOWING WILL OCCUR: [COST \$100]**

- \_\_\_ Discussion of results from changing lifestyles, taking recommended supplements and cleansing [if done].
- \_\_\_ Review results of any additional testing.
- \_\_\_ Repeat bio-impedance analysis to objectively measure any changes.
- \_\_\_ Any additional lifestyle goals will be discussed. Please be writing down your goals.

**BETWEEN APPOINTMENTS:**

- \_\_\_ Take recommended supplements.
- \_\_\_ Eat glycemically balanced every 2-4 hours.
- \_\_\_ Drink at least ½ your body weight in ounces of water daily.
- \_\_\_ Email Dr. Olivia with any questions, changes, improvements and
- \_\_\_ Read the nutrition tips of the Blog page of [www.CookingWithOlivia.com](http://www.CookingWithOlivia.com)
- \_\_\_ Keep a list of any questions for Dr. Olivia on your next visit.

**Note:** More information about the supplements can be found at: [www.metagenics.com](http://www.metagenics.com)

All Natural and Glycemically Balanced Recipes can be found at: [www.CookingWithOlivia.com](http://www.CookingWithOlivia.com)

THE CHIROPRACTIC  
**wellnessconnection**

111 o'fallon commons drive ~ o'fallon 63368  
636.978.0970 ~ www.wellnessconnection-ofallon.com

.....Welcome

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**Nutritional Assessment Questionnaire for Ages 10 & Up**

Personal History

Date: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_

State /Prov: \_\_\_\_\_ Zip/Postal Code: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Cell Phone : \_\_\_\_\_

Sex:         Male     Female

Social Security # \_\_\_\_\_

Circle One:    Married        Single        Divorced        Widowed

E-mail Address: \_\_\_\_\_

How were you referred to our office? \_\_\_\_\_

# THE CHIROPRACTIC wellnessconnection

## Nutritional Assessment Questionnaire for Ages 10 & Up

Please list your top five main health concerns or health goals in order of importance:

- 1) \_\_\_\_\_
- 2) \_\_\_\_\_
- 3) \_\_\_\_\_
- 4) \_\_\_\_\_
- 5) \_\_\_\_\_

Please circle any medications you are currently taking:

|                 |                 |                    |              |
|-----------------|-----------------|--------------------|--------------|
| Antacids        | Asthma Inhalers | Anti-Histamines    | Antibiotics  |
| Antidepressants | Sleeping Pills  | Thyroid medication | Progesterone |
| Estrogen        | Birth Control   | Steroids           | Diuretics    |
| Blood Pressure  | Cholesterol     | Diabetic           | ADD/ADHD     |

Fill in the number that applies: 1=monthly 2=weekly 3=daily

|                             |                                |
|-----------------------------|--------------------------------|
| _____ Artificial Sweeteners | _____ High Fructose Corn Syrup |
| _____ Coffee                | _____ Nicotine                 |
| _____ Fast Food             | _____ Carbonated Beverage      |
| _____ Fried Foods           | _____ Lunch Meat               |
| _____ Margarine             |                                |

Please list how many times you exercise per week: \_\_\_\_\_

Please list any additional vitamins or herbs that you take:

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How many ounces of water are you drinking daily? \_\_\_\_\_ oz/cups

Please fill in the number that applies:

**0 (or leave blank) never**

**1 = Minor of mild symptoms, rarely occurs (once a month or less)**

**2 = It is a moderate symptom or occurs weekly**

**3= It is a severe symptoms and frequently occurs (almost daily)**

### Gastrointestinal Health

- |  |                                |
|--|--------------------------------|
| _____ Belching or gas within an hour of eating | _____ Heartburn/GERD           |
| _____ Bloating or cramping after eating        | _____ Bad Breath               |
| _____ Excess fullness after meals              | _____ Feel better if don't eat |
| _____ Feel like skipping breakfast             | _____ Sleepy after meals       |
| _____ Diarrhea                                 | _____ Constipation             |
| _____ Undigested food in stools                | _____ Nausea                   |
| _____ Stomach upset by greasy foods            | _____ Greasy stools            |
| _____ Headache over the eye                    | _____ Gallbladder attacks      |
| _____ Fibromyalgia                             | _____ Wheat sensitivity        |
| _____ Dairy sensitivity                        | _____ Crohn's disease          |

### Allergies

- |  |                              |
|--|------------------------------|
| _____ Airborne allergies                         | _____ Hives                  |
| _____ Sinus congestion                           | _____ Ear infections         |
| _____ Asthma, frequent respiratory illness       | _____ Eczema                 |
| _____ Dark circles under the eyes                | _____ Coated tongue (white)  |
| _____ Feel worse in moldy or musty places        | _____ Anus itches            |
| _____ Eating sugar or alcohol increases symptoms | _____ Chronic antibiotic use |

*A HIGH SCORE IN THE ABOVE CATEGORIES MAY REQUIRE ADDITIONAL FOOD SENSITIVITY TESTING*

### Vitamin/Mineral Deficiencies

- |                                       |                            |
|---------------------------------------|----------------------------|
| _____ History of Carpal Tunnel        | _____ Reduced bone density |
| _____ White spots on fingernails      | _____ Crave Chocolate      |
| _____ Tendency to Anemia              | _____ Lump in throat       |
| _____ Bursitis or tendonitis          | _____ Joints pop or click  |
| _____ Muscles easily fatigue          | _____ Poor Memory          |
| _____ Restless leg syndrome           | _____ Ringing in ears      |
| _____ Depression                      | _____ Anxiety              |
| _____ Small bumps on the back of arms | _____ Water retention      |
| _____ Polycystic ovarian syndrome     | _____ PMS                  |
| _____ Breast tenderness               | _____ Severe cramping      |
| _____ Heavy bleeding with cycles      | _____ Hot Flashes          |
| _____ Irregular menstrual cycles      | _____ Insomnia             |
| _____ Excess facial or body hair      | _____ Vaginal Dryness      |

Please fill in the number that applies:

**0 (or leave blank) never**

**1 = Minor of mild symptoms, rarely occurs (once a month or less)**

**2 = It is a moderate symptom or occurs weekly**

**3= It is a severe symptoms and frequently occurs (almost daily)**

### **Blood Sugar/Adrenal**

- |  |                              |
|--|------------------------------|
| _____ Eat desserts or sugary snacks            | _____ Sleepy in afternoon    |
| _____ Fatigue all day                          | _____ Crave Sweets           |
| _____ Headaches if meals skipped or delayed    | _____ Crave Salty Foods      |
| _____ Become dizzy when standing up suddenly   | _____ Low blood pressure     |
| _____ Store fat in abdomen                     | _____ Sensitive to light     |
| _____ Perspire easily, even if not hot         | _____ Keyed up, jittery      |
| _____ Excessive appetite                       | _____ Binge eating           |
| _____ Crave caffeine or sugar in the afternoon | _____ Irritable before meals |

### **Hormone/Thyroid (a high score in this category may require additional testing)**

- |                                   |                        |
|-----------------------------------|------------------------|
| _____ Wake up with headaches      | _____ Low Libido       |
| _____ Coarse hair/hair loss       | _____ Loss of eyebrows |
| _____ Mentally sluggish           | _____ Flush easily     |
| _____ Difficulty losing weight    | _____ Seasonal sadness |
| _____ Difficulty conceiving       | _____ Endometriosis    |
| _____ Polycystic ovarian syndrome | _____ PMS              |
| _____ Breast tenderness           | _____ Severe cramping  |
| _____ Heavy bleeding with cycles  | _____ Hot Flashes      |
| _____ Irregular menstrual cycles  | _____ Insomnia         |
| _____ Excess facial or body hair  | _____ Vaginal Dryness  |

# Daily Food Log

Please Fill Out Completely With Your ***Typical*** Food Choices

|               | <b>Day 1</b>   |               | <b>Day 2</b>   |               | <b>Day 3</b>   |
|---------------|----------------|---------------|----------------|---------------|----------------|
| Time          | Breakfast:     | Time          | Breakfast:     | Time          | Breakfast:     |
| Time          | Mid-Morning:   | Time          | Mid-Morning:   | Time          | Mid-Morning:   |
| Time          | Lunch:         | Time          | Lunch:         | Time          | Lunch:         |
| Time          | Mid-Afternoon: | Time          | Mid-Afternoon: | Time          | Mid-Afternoon: |
| Time          | Dinner:        | Time          | Dinner:        | Time          | Dinner:        |
| Time          | Evening:       | Time          | Evening:       | Time          | Evening:       |
| Ounces        | Water Intake:  | Ounces        | Water Intake:  | Ounces        | Water Intake:  |
|               | Other Drinks:  |               | Other Drinks:  |               | Other Drinks:  |
| Scale<br>1-10 | Energy:        | Scale<br>1-10 | Energy:        | Scale<br>1-10 | Energy:        |
| Scale<br>1-10 | Sleep Quality: | Scale<br>1-10 | Sleep Quality: | Scale<br>1-10 | Sleep Quality: |