

Nutritional Counseling Food Sensitivity Testing Neurotransmitter Testing Hormone Testing Wellness & Prevention	THE CHIROPRACTIC <b>wellnessconnection</b> 111 O'Fallon Commons Drive O'Fallon, MO 63368 636-978-0970	Dr. Olivia Joseph Certified Clinical Nutritionist Board Certified Acupuncturist  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:**

<b>1st Appointment DATE:</b> _____ <b>TIME:</b> _____ 30 minute evaluation
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- \_\_\_\_\_ 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):**

<b>2nd APPOINTMENT DATE:</b> _____ Before appointment watch the " <i>Do I need Vitamins?</i> " video at <a href="http://www.CookingWithOlivia.com">www.CookingWithOlivia.com</a>
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<b>3rd APPOINTMENT DATE:</b> _____ 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.
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**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-impedence 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 9 & Under**

Personal History

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

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

Parent/Legal Guardian 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 9 & Under

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

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

Please circle any medications your child is currently taking:

Antacids	Asthma Inhalers	Anti-Histamines	Antibiotics
Antidepressants	ADD/ADHD	Steroids	Other _____

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

_____ Artificial Sweeteners	_____ High Fructose Corn Syrup	_____ Caffeine
_____ Fast Food	_____ Carbonated Beverage	_____ Desserts
_____ Fried Foods	_____ Lunch Meat	_____ Margarine

Please list any additional vitamins or herbs that your child takes:

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How many ounces of water does your child drink daily? \_\_\_\_\_ oz/cups

What additional fluids are being used daily? \_\_\_\_\_ oz/cups

### **Past Healthy History**

Was the birth:      vaginally      c-section      forceps      vacuum

How many times had your child taken antibiotics in his/her lifetime? \_\_\_\_\_

Please list any hospitalizations or surgeries: \_\_\_\_\_

Did your child have colic or reflux as a baby? \_\_\_\_\_

Was your child breast or formula fed? If formula, what kind? \_\_\_\_\_

Please fill in the number that applies:

**0 (or leave blank) never**

**1 = Minor or 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       |
| _____ Headache over the eye                    | _____ Wheat sensitivity        |
| _____ Dairy sensitivity                        | _____ Crohn's disease          |

### **Allergies**

- |  |                              |
|--|------------------------------|
| _____ Airborne allergies                   | _____ Hives                  |
| _____ Sinus congestions                    | _____ 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 increases symptoms      | _____ Chronic antibiotic use |

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

### **Mineral and Essential Fatty Acid Deficiency**

- |                                       |                           |
|---------------------------------------|---------------------------|
| _____ White spots on fingernails      | _____ Crave Chocolate     |
| _____ Tendency to Anemia              | _____ Difficulty Focusing |
| _____ Hyperactivity                   | _____ Impulsivity         |
| _____ Tosses and turns while sleeping | _____ Unable to calm down |
| _____ Depression                      | _____ Anxiety             |
| _____ Small bumps on the back of arms | _____ Water retention     |
| _____ Physically abusive              | _____ Anger               |

*A high score in this category may require additional neurotransmitter testing*

### **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 |

# 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 1-10	Energy:	Scale 1-10	Energy:	Scale 1-10	Energy:
Scale 1-10	Sleep Quality:	Scale 1-10	Sleep Quality:	Scale 1-10	Sleep Quality: