NUTRITION HISTORY FORM

Please complete this form and the food record and email (drthoma@infinityspine.com) or fax (480-345-2199) to Infinity Spine Center at least 48 hours before your consultation.

Last Name: ________________________ First Name:_________________________

What name do you prefer to go by?____

Address:____ APT#:___________

City:_____________________________ State:__________ Zip Code:____________

Email (for office use only):____

Home Phone: (_______)____________Work Phone:(_______)________________
Cell: (_______)____________Fax Line: (_______)____________________

Age: _____ Date of Birth _____/_____/______Gender: Male _____ Female_____

Primary Physician: _______________________ Phone number: _________________

What's your current physical activity level (check the one that best quantifies your activity level and then please describe your activites in detail below)?

_____Active (≥3 times/week) _____Inactive (<3 times/week) _____Not exercising routinely

If you do exercise, please describe (cardio on elliptical 3x/week for 30 min/session):

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Personal medical history (check all that apply to past and/or present):

Past	*Present*		*Past*	*Present*	
____	____	Diabetes	____	____	Migraines
____	____	Heart Disease	____	____	Anemia
____	____	High blood pressure	____	____	Chronic Fatigue
____	____	Stroke	____	____	Fibromyalgia
____	____	Obesity	____	____	IBS
____	____	Elevated cholesterol	____	____	Crohn's
____	____	Elevated Triglycerides	____	____	Celiac
____	____	Sleep apnea	____	____	Food Allergy
____	____	Gallstones	____	____	Physical inactivity
____	____	Reflux disease	____	____	Smoker
____	____	Chronic constipation	____	____	Alcohol
____	____	Ulcers			
____	____	Asthma	Other ____________________		
____	____	Arthritis			
			Other ____________________		

FOOD SCORE SHEET

Check the answer that indicates your USUAL intake

____I eat breakfast most mornings
____I eat at least 4 meals or snacks a day
____I eat my largest meal in the evening
____I avoid eating seconds during meals
____I usually have a snack or dessert after my evening meal
____When at home, I only eat at the kitchen or dining room table
____When at work, I avoid eating at my desk.
____I am relaxed and enjoy eating
____I allow at least 20 minutes to complete my meals
____I avoid doing other things while eating, ie reading the newspaper, watching TV, internet
____I eat out less than 2 times a week.
____I eat protein (meat/fish/poultry/beans/dairy/nuts) with each meal
____I avoid visible fats on meats
____I only eat high fiber cereal and whole grain breads, pastas etc.
____I eat bread or potatoes with most meals other than breakfast
____I avoid beverages with sugar (regular sodas, sports drinks, sweet tea, fruit juice)
____I drink at least 32 oz of water a day
____I avoid sweets most days.
____I avoid adding salt to my food
____I consume yogurt, cheese, cottage cheese or milk most days
____I eat 5 servings of fruit and vegetables day (1/2 cup = 1 serving)
____I eat 3 different varieties of fruits and vegetables most days
____I avoid fried foods
____I watch my calorie intake
____I watch my fat intake
____I watch my carbohydrate intake
____I get hungry within 2 hours of eating a meal

____I drink less than 2 alcoholic beverages each day
____I have a desk job, or one that requires little activity
____I exercise at least 4 days out of the week
____I am rested when I wake up in the morning

Have you made any recent changes in the foods or liquids that you consume or your exercise routine?
(circle one) Yes No

If yes, please describe:

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What would you like to accomplish in working with me:

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Motivation List

Please make a list of things you want to change in your life that can be accomplished with lifestyle changes. These will be what motivates you, keeps you on track and reminds you why you are working toward a healthier, optimal functioning, vital you.

1.____

2.____

3.____

4.____

6.____

7.____

8.____

9.____

10.____

Food Record Instructions:

1. Keep the record for a **minimum** of 3 days (more days are better but not necessary), and one of the days **must** be a weekend day.

2. Please estimate the portion sizes as accurately as possible. Portion sizes help us to serve you better.

3. Be honest with yourself. This is **not** done to judge you or anything you do. We cannot set about addressing a problem until we know what it is. Try not to change your eating habits because you know we will be reading your food record-it will be confidential. This exercise will also serve to make you aware of habits or tendencies that you may not be aware of and may be an eye-opening experience for you.

Daily Record of Food Intake

I Your diet is key to optimal health. Each day record all the items you eat and drink. Be sure to include the amount of each item. Be sure to bring this record to your consultation.

Name:____Date:____________________________

Day 1

BREAKFAST Time:___________________________

Water (type): (fl. Oz.)_______________________________

Vegetables:_____________________________________

Meat:____

Dairy:____

Fruits:____

Breads, Cereals, & Grains:___________________________

Fats (butter, margarine, oils, etc.):_____________________

Candy, Sweets, & Junk Food:_________________________

Other Drinks:____________________________________

LUNCH Time: ___________________________

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DINNER Time:___________________________

Water (type): (fl. Oz.)_______________________________

Vegetables:_____________________________________

Meat:____

Dairy:____

Fruits:____

Breads, Cereals, & Grains:___________________________

Fats (butter, margarine, oils, etc.):_____________________

Candy, Sweets, & Junk Food:_________________________

Other Drinks:____________________________________

MID-MORNING SNACK Time:______________

Snack:________________________________

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MID-DAY SNACK Time:______________

Snack:________________________________

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EVENING SNACK Time:______________

Snack:________________________________

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TOTAL CLEAN WATER TODAY (fl. Oz):_______

Hours of Sleep:______________ Quality of Sleep (1-4; 1=good; 4=poor):________________________________

Number of Bowel Movements:_____________ Consistency:____________________________

Supplements:____

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Medications:____

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Notes:____

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Day 2

BREAKFAST Time:______________________________

Water (type): (fl. Oz.)__________________________________

Vegetables:____

Meat:____

Dairy:____

Fruits:____

Breads, Cereals, & Grains:____________________________

Fats (butter, margarine, oils, etc.):_________________________

Candy, Sweets, & Junk Food:____________________________

Other Drinks:____

LUNCH Time: ______________________________

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DINNER Time:______________________________

Water (type): (fl. Oz.)__________________________________

Vegetables:____

Meat:____

Dairy:____

Fruits:____

Breads, Cereals, & Grains:____________________________

Fats (butter, margarine, oils, etc.):_________________________

Candy, Sweets, & Junk Food:____________________________

Other Drinks:____

MID-MORNING SNACK Time:_________________

Snack:___________________________________

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MID-DAY SNACK Time:_________________

Snack:___________________________________

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EVENING SNACK Time:_________________

Snack:___________________________________

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TOTAL CLEAN WATER TODAY (fl. Oz):________

Hours of Sleep:_______________ Quality of Sleep (1-4; 1=good; 4=poor):____________________________________

Number of Bowel Movements:_______________ Consistency:_______________________________

Supplements:____

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Medications:____

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Notes:____

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Day 3

BREAKFAST Time:_______________________________

Water (type): (fl. Oz.)___________________________________

Vegetables:____

Meat:____

Dairy:____

Fruits:____

Breads, Cereals, & Grains:______________________________

Fats (butter, margarine, oils, etc.):_________________________

Candy, Sweets, & Junk Food:_____________________________

Other Drinks:____

LUNCH Time: _______________________________

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DINNER Time:_______________________________

Water (type): (fl. Oz.)___________________________________

Vegetables:____

Meat:____

Dairy:____

Fruits:____

Breads, Cereals, & Grains:______________________________

Fats (butter, margarine, oils, etc.):_________________________

Candy, Sweets, & Junk Food:_____________________________

Other Drinks:____

MID-MORNING SNACK Time:_________________

Snack:____________________________________

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MID-DAY SNACK Time:_________________

Snack:____________________________________

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EVENING SNACK Time:_________________

Snack:____________________________________

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TOTAL CLEAN WATER TODAY (fl. Oz):________

Hours of Sleep:_______________ Quality of Sleep (1-4; 1=good; 4=poor):_____________________________________

Number of Bowel Movements:_______________ Consistency:________________________________

Supplements:____

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Medications:____

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Notes:____

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Day 4

BREAKFAST Time:______________________________

Water (type): (fl. Oz.)_________________________________

Vegetables:____

Meat:____

Dairy:____

Fruits:____

Breads, Cereals, & Grains:_____________________________

Fats (butter, margarine, oils, etc.):________________________

Candy, Sweets, & Junk Food:____________________________

Other Drinks:_______________________________________

LUNCH Time: ______________________________

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DINNER Time:______________________________

Water (type): (fl. Oz.)_________________________________

Vegetables:____

Meat:____

Dairy:____

Fruits:____

Breads, Cereals, & Grains:_____________________________

Fats (butter, margarine, oils, etc.):________________________

Candy, Sweets, & Junk Food:____________________________

Other Drinks:_______________________________________

MID-MORNING SNACK Time:_________________

Snack:__________________________________

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MID-DAY SNACK Time:_________________

Snack:__________________________________

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EVENING SNACK Time:_________________

Snack:__________________________________

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TOTAL CLEAN WATER TODAY (fl. Oz):________

Hours of Sleep:_______________ Quality of Sleep (1-4; 1=good; 4=poor):_______________________________________

Number of Bowel Movements:_______________ Consistency:________________________________

Supplements:____

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Medications:____

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Notes:____

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Day 5

BREAKFAST Time:___	LUNCH Time: ___
Water (type): (fl. Oz.)___	___
Vegetables:___	___
Meat:___	___
Dairy:___	___
Fruits:___	___
Breads, Cereals, & Grains:___	___
Fats (butter, margarine, oils, etc.):___	___
Candy, Sweets, & Junk Food:___	___
Other Drinks:___	___
DINNER Time:___	MID-MORNING SNACK Time:___
Water (type): (fl. Oz.)___	Snack:___
Vegetables:___	___
Meat:___	MID-DAY SNACK Time:___
Dairy:___	Snack:___
Fruits:___	___
Breads, Cereals, & Grains:___	EVENING SNACK Time:___
Fats (butter, margarine, oils, etc.):___	Snack:___
Candy, Sweets, & Junk Food:___	___
Other Drinks:___	TOTAL CLEAN WATER TODAY (fl. Oz):___

Hours of Sleep:___ Quality of Sleep (1-4; 1=good; 4=poor):___

Number of Bowel Movements:___ Consistency:___

Supplements:___

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Medications:___

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Notes:___

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Day 6

BREAKFAST Time:______________________________

Water (type): (fl. Oz.)__________________________________

Vegetables:____

Meat:____

Dairy:____

Fruits:____

Breads, Cereals, & Grains:______________________________

Fats (butter, margarine, oils, etc.):_________________________

Candy, Sweets, & Junk Food:____________________________

Other Drinks:____

LUNCH Time: ______________________________

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DINNER Time:______________________________

Water (type): (fl. Oz.)__________________________________

Vegetables:____

Meat:____

Dairy:____

Fruits:____

Breads, Cereals, & Grains:______________________________

Fats (butter, margarine, oils, etc.):_________________________

Candy, Sweets, & Junk Food:____________________________

Other Drinks:____

MID-MORNING SNACK Time:_________________

Snack:___________________________________

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MID-DAY SNACK Time:_________________

Snack:___________________________________

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EVENING SNACK Time:_________________

Snack:___________________________________

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TOTAL CLEAN WATER TODAY (fl. Oz):________

Hours of Sleep:_______________ Quality of Sleep (1-4; 1=good; 4=poor):_______________________________________

Number of Bowel Movements:_______________ Consistency:_______________________________

Supplements:____

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Medications:____

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Notes:____

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Day 7

BREAKFAST Time:______________________________

Water (type): (fl. Oz.)_________________________________

Vegetables:____

Meat:____

Dairy:____

Fruits:____

Breads, Cereals, & Grains:______________________________

Fats (butter, margarine, oils, etc.):________________________

Candy, Sweets, & Junk Food:____________________________

Other Drinks:____

DINNER Time:______________________________

Water (type): (fl. Oz.)_________________________________

Vegetables:____

Meat:____

Dairy:____

Fruits:____

Breads, Cereals, & Grains:______________________________

Fats (butter, margarine, oils, etc.):________________________

Candy, Sweets, & Junk Food:____________________________

Other Drinks:____

LUNCH Time: ______________________________

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MID-MORNING SNACK Time:_________________

Snack:___________________________________

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MID-DAY SNACK Time:_________________

Snack:___________________________________

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EVENING SNACK Time:_________________

Snack:___________________________________

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TOTAL CLEAN WATER TODAY (fl. Oz):________

Hours of Sleep:_______________ Quality of Sleep (1-4; 1=good; 4=poor):_______________________________________

Number of Bowel Movements:_______________ Consistency:_______________________________

Supplements:____

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Medications:____

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Notes:____

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