Nutrition Intake Form

Name: _____ Date: _____

Gender: M □ F □ Height: _____ Weight: _____ Birth Date: _____ Age: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Cell phone: ( ) _____ Home phone: ( ) _____ Work phone: ( ) _____

Email: _____ Marital Status: □ S □ M □ D □ W □ O

Receive appointment reminders via □ **Email** or □ **Text** and please provide **Cell Carrier** _____

Occupation: _____ Number of years in this type of work: _____

Emergency Contact: _____

Referred by: _____

CURRENT HEALTH CONDITIONS

Primary health concern: _____

List any food allergies: _____

Do you currently drink alcohol? □ Yes □ No □ 1-2x/week □ 3-5x/week □ 6-7x/week

How much water in ounces do you drink daily? _____

Do you use CBD/THC products? □ Yes □ No

Do you smoke tobacco? □ Yes □ No

FEMALE ONLY

When was your last menstrual cycle? _____

Are you on ANY form of birth control? If yes, what kind? How long?_____

MALE ONLY

Do you get up during the night to urinate? If so, how many times?_____

DIAGNOSES

List all past diagnoses or conditions that were given to you by a healthcare provider.
(Ex: MD, Acupuncturist, Chiropractor, etc.)

Date	Diagnosis	Care Given

PRESCRIPTIONS

Medications	What's it for?	# of years		Medications	What's it for?	# of years

HOSPITALIZATIONS & SURGERIES

List all past medical conditions for which you were hospitalized and/or received surgery and any diagnosis that resulted from the incident.

Date	Reason (hospitalization or surgery)	Diagnosis (if applicable)

LABS OR TESTS

Please bring in your most recent bloodwork (within 1 year), saliva tests, hair analysis, ZYTO scans, etc. If you need to contact your MD to send us your most recent test results, please have them faxed to us at 916-596-6952.

NOTES

_____

_____

_____

_____

CONSENT TO TREAT A MINOR

If under 18, person responsible for your account and their relationship to you:

_____

FINANCIAL AGREEMENT

I understand that all services are rendered on a cash, check, credit card or HSA basis. Unless other arrangements have been made and approved, I agree to pay for each session and/or supplements at the time given. I understand that my insurance will not be billed for these services.

Signature_____ Date_____

NOTICE OF CANCELLATION POLICY

If you need to cancel or reschedule your appointment, we ask that you give us 24 hours notice (48 hours for Chico appointment) so we can schedule another patient. If we do not receive sufficient notice, a $25 cancellation fee will be charged to your account. I understand and agree to the cancellation policy.

Signature_____ Date_____

NOTICE OF UNDERSTANDING AND AGREEMENT

I hereby, attest to the following:

1. I fully understand that the Nutritional Consultant I am seeing in this office is not a physician, and I am not consulting for medical, diagnostic, or treatment procedures.
2. The services performed by the Nutritional Consultant are at all times restricted to helping me gain a better understanding of my degree of "health" (not disease), so I will have a greater self-awareness and be able to use a self-care program for daily living.
3. I understand that as a Nutritional Consultant the recommendation, discussion, sale of food, nutrition, nutritional supplements, vitamins or minerals, food grade herbs, or other nutrients as foods for special dietary use only pertains to the whole-body concept of nutrition, and does not relate in the context of an specific ailment or condition.
4. The appointments do not involve the diagnosing, prognosticating, treating, or prescribing of medicines or the treatment of disease or any act which will constitute the practice of medicine in this state, for which a medical license is required.

Signature_____ Date_____

Please email or mail your paperwork back to the office with enough time to be reviewed before your appointment. If you have issues downloading the paperwork, please do not hesitate to contact our office.

2371 Iron Point Rd, Ste 130
Folsom, CA 95630
virbydc@gmail.com
916-844-2800

Systems Assessment Form

Name: _____ Age: _____ Sex: _____ Date: _____

List your 5 main health complaints in the order of importance:

1. _____
2. _____
3. _____
4. _____
5. _____

Weight: _____ ❑ Vegetarian ❑ Vegan

Height: _____ ❑ Gluten-free ❑ Dairy-free

Organs Removed:

❑ Gallbladder ❑ Thyroid ❑ Colon ❑ Spleen
❑ Uterus ❑ Ovaries ❑ Breast ❑ Prostate
❑ Tonsils ❑ Appendix ❑ Other: _____

Circle the appropriate number that applies on all questions below. 0 is the least/never to 3 as the most/always

Group 1

1. Acid foods upset 0 1 2 3
2. Get the chills often 0 1 2 3
3. "Lump" in throat 0 1 2 3
4. Dry mouth, eyes, or nose 0 1 2 3
5. Pulse increases after a meal 0 1 2 3
6. Keyed up, difficult to calm down 0 1 2 3
7. Cuts or scratches heal slowly 0 1 2 3
8. Gag easily 0 1 2 3
9. Unable to relax; startle easily 0 1 2 3
10. Clammy or cold hands/feet 0 1 2 3
11. Irritated by strong light 0 1 2 3
12. Urine amount reduced 0 1 2 3
13. Heart pounds after retiring 0 1 2 3
14. "Nervous" stomach 0 1 2 3
15. Forgets to eat meals 0 1 2 3
16. Cold sweats 0 1 2 3
17. Temperature raises easily, fevers 0 1 2 3
18. Skin sensitive or painful if touched 0 1 2 3
19. Eyes lock in fixed stare (few seconds) 0 1 2 3
20. Queasy or sour stomach 0 1 2 3

Group 2

21. Joint stiffness on arising 0 1 2 3
22. Muscle, leg, or toe cramps at night 0 1 2 3
23. "Butterfly" stomach, cramps 0 1 2 3
24. Eyes or nose watery 0 1 2 3
25. Eyes blink rapidly 0 1 2 3
26. Eyelids swollen or puffy 0 1 2 3
27. Indigestion soon after meals 0 1 2 3
28. Always feel hungry; "lightheaded" often 0 1 2 3
29. Digestion is rapid 0 1 2 3
30. Occasional nausea or vomiting 0 1 2 3
31. Voice gets hoarse or raspy 0 1 2 3
32. Slow or Irregular breathing pattern 0 1 2 3
33. Pulse skips or feels "irregular" 0 1 2 3
34. Excessive saliva production 0 1 2 3
35. Difficulty swallowing food or pills 0 1 2 3
36. Alternating constipation & diarrhea 0 1 2 3
37. Slow starter in the morning 0 1 2 3
38. Ears get hot or red 0 1 2 3
39. Sweat easily 0 1 2 3
40. Feel cold – hands, feet, all over 0 1 2 3
41. Colds or respiratory infections 0 1 2 3

Group 3

42. Eat when nervous or anxious 0 1 2 3
43. Excessive appetite 0 1 2 3
44. Hungry between meals 0 1 2 3
45. Irritated before meals (hangry) 0 1 2 3
46. Get "shaky" or "jittery" if hungry 0 1 2 3
47. Fatigue after meals (food coma) 0 1 2 3
48. "Lightheaded" if meals delayed 0 1 2 3
49. Can feel heart beat, palpitates 0 1 2 3
50. Afternoon Headaches 0 1 2 3
51. Bloating after eating fiber, starch, sugar 0 1 2 3
52. Insomnia: Cannot stay asleep 0 1 2 3
53. Crave candy or coffee during the day 0 1 2 3
54. Depression, lack of motivation 0 1 2 3
55. Crave sweets or snacks during the day 0 1 2 3

Group 4

56. Hands or feet go to sleep, numbness 0 1 2 3
57. Sigh frequently, "Air hunger" 0 1 2 3
58. Aware of "breathing heavily" 0 1 2 3
59. High-Altitude discomfort 0 1 2 3
60. Feel must open windows in closed rooms 0 1 2 3
61. Easily gets colds or fevers 0 1 2 3
62. Afternoon "yawner" 0 1 2 3
63. Feel "drowsy" 0 1 2 3
64. Ankle or wrist swelling, fluid retention 0 1 2 3
65. Muscle cramps 0 1 2 3
66. Shallow, rapid breathing 0 1 2 3
67. Chest tightness, pressure or pain 0 1 2 3
68. Bruise easily, "black and blue" spots 0 1 2 3
69. Tendency to Anemia 0 1 2 3
70. "Nose bleeds" 0 1 2 3
71. Noises in head, or "ringing in ears" 0 1 2 3
72. Shortness of breath upon exertion 0 1 2 3

Group 5

73. Dizziness 0 1 2 3
74. Dry or flaky skin (scalp, feet, anywhere) 0 1 2 3
75. Burning or itching feet 0 1 2 3
76. Blurred vision 0 1 2 3
77. Unexplained itching skin or rash anywhere 0 1 2 3
78. Excessive falling hair 0 1 2 3
79. Reddened skin, especially palms or feet 0 1 2 3
80. Bitter or metallic taste in mouth in mornings 0 1 2 3
81. Bowel movements painful or difficult 0 1 2 3
82. Worrier, feel insecure 0 1 2 3
83. Tightness/headache over eyes 0 1 2 3
84. Greasy or high-fat foods cause distress 0 1 2 3
85. Stool color is pale, white or light colored 0 1 2 3
86. Perfume/fragrance sensitivity 0 1 2 3
87. Muscle tightness between shoulder blades 0 1 2 3
88. Occasional constipation 0 1 2 3
89. Stools alternate from soft to watery 0 1 2 3
90. History of gallbladder spasms or stones 0 1 2 3
91. Sneezing attacks 0 1 2 3
92. Nightmare-type dreams or terrors 0 1 2 3
93. Bad breath (halitosis) 0 1 2 3
94. Dairy, Milk products cause distress or lactose intolerant 0 1 2 3
95. Sensitive to hot weather 0 1 2 3
96. Itching or burning anus 0 1 2 3
97. Sweet and sour cravings 0 1 2 3

Group 6

98. Loss of interest to eat meat 0 1 2 3
99. Use antacids 0 1 2 3
100. Burning stomach relieved by eating 0 1 2 3
101. White coating on tongue 0 1 2 3
102. Pass large amounts of foul-smelling gas 0 1 2 3
103. Bloating lasts hours after eating 0 1 2 3
104. Unpredictable urgency to defecate 0 1 2 3
105. Pass large amounts of gas: No odor 0 1 2 3
106. Heartburn when lying down 0 1 2 3

Symptoms listed on this form are not intended to be used as a diagnosis of any disease or condition.

Group 7A

107. Insomnia: Hard to fall asleep 0 1 2 3
108. Nervousness, feel on edge 0 1 2 3
109. Difficult to gain weight 0 1 2 3
110. Intolerance to heat 0 1 2 3
111. Highly emotional 0 1 2 3
112. Face or skin flushes easily 0 1 2 3
113. Night sweats 0 1 2 3
114. Thin, moist skin 0 1 2 3
115. Inward trembling 0 1 2 3
116. Can hear heartbeat on pillow 0 1 2 3
117. Increased appetite but can't gain weight 0 1 2 3
118. Increased or rapid pulse at rest 0 1 2 3
119. Eyelids or face twitch 0 1 2 3
120. Irritable and restless 0 1 2 3
121. Difficulty working under pressure 0 1 2 3

Group 7B

122. Increase in weight 0 1 2 3
123. Decrease in appetite 0 1 2 3
124. Fatigue easily 0 1 2 3
125. Ringing in ears (Pitch: ❑ High ❑ Low) 0 1 2 3
126. Sleepy during day 0 1 2 3
127. Sensitive to cold 0 1 2 3
128. Dry or scaly skin 0 1 2 3
129. Use laxatives 0 1 2 3
130. Mental sluggishness 0 1 2 3
131. Hair coarse or falling out 0 1 2 3
132. Headaches in mornings, wear off during the day 0 1 2 3
133. Slow pulse, below 65 0 1 2 3
134. Frequent urination 0 1 2 3
135. Impaired or loss of hearing 0 1 2 3
136. Reduced initiative or motivation 0 1 2 3

Group 7C

137. Failing memory 0 1 2 3
138. Low blood pressure 0 1 2 3
139. Increased sex drive 0 1 2 3
140. "Splitting or rending" headache near the temple 0 1 2 3
141. Cannot handle sugar well 0 1 2 3

Group 7D

142. Thirsty all the time 0 1 2 3
143. Bloating of abdomen 0 1 2 3
144. Weight gain around hips or waist 0 1 2 3
145. Sex drive reduced or lacking 0 1 2 3
146. Tendency to ulcers, colitis 0 1 2 3
147. Can eat and burn sugar easily 0 1 2 3
148. Increased urine output 0 1 2 3
149. Sexual dysfunction 0 1 2 3

Group 7E

150. Dizzy after standing up quickly 0 1 2 3
151. Headaches that go away with caffeine 0 1 2 3
152. Hot flashes 0 1 2 3
153. Increased blood pressure 0 1 2 3
154. Thinning skin on arms or hands 0 1 2 3
155. Urine smells sweet or fruity 0 1 2 3
156. Masculine tendencies (female) 0 1 2 3

Group 7F

157. Weakness, dizziness 0 1 2 3
158. Chronic fatigue 0 1 2 3
159. Low blood pressure 0 1 2 3
160. Weak nails or have ridges 0 1 2 3
161. Tendency to hives 0 1 2 3
162. Joint pain and stiffness 0 1 2 3
163. Perspiration increase 0 1 2 3
164. Bowel inflammation 0 1 2 3
165. Poor circulation 0 1 2 3
166. Swelling of ankles (❑ Left ❑ Right) 0 1 2 3
167. Crave salt 0 1 2 3
168. Brown spots or bronzing of skin 0 1 2 3
169. Allergies 0 1 2 3
170. Weakness after colds, influenza 0 1 2 3
171. Exhaustion - muscular and nervous 0 1 2 3
172. Respiratory or breathing challenges 0 1 2 3

Group 8 | B Complex

173. Muscle weakness 0 1 2 3
174. Lack of Stamina 0 1 2 3
175. Drowsiness after eating 0 1 2 3
176. Muscular soreness 0 1 2 3
177. Rapid heart beat 0 1 2 3
178. Hyper-irritable 0 1 2 3
179. Feeling of a band around the head 0 1 2 3
180. Melancholia (feeling of sadness) 0 1 2 3
181. Difficult to concentrate 0 1 2 3
182. Diminished urination 0 1 2 3
183. Tendency to consume sweets or carbohydrates 0 1 2 3

Group 8 | G Complex

184. Muscle spasms, twitches 0 1 2 3
185. Anxiety 0 1 2 3
186. Loss of muscular control 0 1 2 3
187. Numbness 0 1 2 3
188. Night sweats 0 1 2 3
189. Rapid digestion 0 1 2 3
190. Sensitivity to noise 0 1 2 3
191. Cracking of skin, hands or bottom of feet 0 1 2 3
192. Visible veins on chest and abdomen 0 1 2 3
193. Hemorrhoids or spider veins 0 1 2 3
194. Apprehension (feeling that something bad will happen) 0 1 2 3
195. Nervousness causing loss of appetite 0 1 2 3
196. Nervousness with indigestion 0 1 2 3
197. Gastritis 0 1 2 3
198. Forgetfulness 0 1 2 3
199. Thinning hair 0 1 2 3

FEMALE ONLY

200. Very easily fatigued 0 1 2 3
201. Premenstrual tension 0 1 2 3
202. Painful menses or ovulation 0 1 2 3
203. Depressed feelings before menstruation 0 1 2 3
204. Menstruation excessive and prolonged 0 1 2 3
205. Painful breasts 0 1 2 3
206. Menstruate too frequently 0 1 2 3
207. Vaginal discharge 0 1 2 3
208. Hair growth on face (upper lip, chin) areola, abdomen 0 1 2 3
209. Hot flashes 0 1 2 3
210. Menses scanty or missed 0 1 2 3
211. Acne, worse at menses 0 1 2 3
212. Raised bumps on skin of arm 0 1 2 3

MALE ONLY

213. Prostate challenges 0 1 2 3
214. Urination difficult or dribbling 0 1 2 3
215. Frequent night urination 0 1 2 3
216. Depression, melancholy 0 1 2 3
217. Pain on inside of legs or heels 0 1 2 3
218. Feeling of incomplete bowel evacuation 0 1 2 3
219. Lack of energy 0 1 2 3
220. Migrating aches or pain 0 1 2 3
221. Tire too easily 0 1 2 3
222. Avoid social activity 0 1 2 3
223. Restless legs at night 0 1 2 3
224. Diminished sex drive 0 1 2 3

OFFICE USE ONLY

❑ Food Diary
❑ Tongue
❑ Fingernails

Zinc Test Results: _____

Postural Hypotension:

Recumbent: _____ / _____ Pulse: ____

Standing: _____ / _____ Pulse: ____

SpO_2: _____%

Calcium Cuff Test:

Before: _____ After: _____

The Nutritional Exam:

❑ HCL ❑ Ascending
❑ Enzyme ❑ Transverse
❑ Murphy's Sign ❑ Descending

Notes:

Symptoms listed on this form are not intended to be used as a diagnosis of any disease or condition.

Daily Record of Food Intake | *Your diet may be the key to better health.*

Each day, record all the items you eat and drink. Be sure to include the approximate amount of each item. When you have completed this form, return it to your health care professional for evaluation.

Standard Process®

Name: _____

Day 1 - Date:

BREAKFAST *Time:*	***LUNCH*** *Time:*	***DINNER*** *Time:*
Meat & Dairy:		
Vegetables & Fruits:		
Breads, Cereals, & Grains:		
Fats (butter, margarine, oils, etc.):		
Candy, Sweets, & Junk Food:		
Water Intake (fl. oz.):		
Other Drinks:		
MID-MORNING SNACK *Time:*	***MID-DAY SNACK*** *Time:*	***NIGHTTIME SNACK*** *Time:*
Snack:		
Bowel Movements(# and consistency):	***Hours of Sleep:***	***Quality of Sleep:*** (good) 1 2 3 4 5 (poor)

Day 2 - Date:

BREAKFAST *Time:*	***LUNCH*** *Time:*	***DINNER*** *Time:*
Meat & Dairy:		
Vegetables & Fruits:		
Breads, Cereals, & Grains:		
Fats (butter, margarine, oils, etc.):		
Candy, Sweets, & Junk Food:		
Water Intake (fl. oz.):		
Other Drinks:		
MID-MORNING SNACK *Time:*	***MID-DAY SNACK*** *Time:*	***NIGHTTIME SNACK*** *Time:*
Snack:		
Bowel Movements(# and consistency):	***Hours of Sleep:***	***Quality of Sleep:*** (good) 1 2 3 4 5 (poor)

Day 3 - Date:

BREAKFAST *Time:*	***LUNCH*** *Time:*	***DINNER*** *Time:*
Meat & Dairy:		
Vegetables & Fruits:		
Breads, Cereals, & Grains:		
Fats (butter, margarine, oils, etc.):		
Candy, Sweets, & Junk Food:		
Water Intake (fl. oz.):		
Other Drinks:		
MID-MORNING SNACK *Time:*	***MID-DAY SNACK*** *Time:*	***NIGHTTIME SNACK*** *Time:*
Snack:		
Bowel Movements(# and consistency):	***Hours of Sleep:***	***Quality of Sleep:*** (good) 1 2 3 4 5 (poor)

Notes: _____