



**HOLISTIC NUTRITIONAL COUNSELING
SHERRY DELL, PHD, CN**

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Health and Lifestyle History

GENERAL

Name _____ Birthdate and Time _____

Age _____ Address _____ City/State _____

Zip _____ Home Phone _____ Work Phone _____

Height _____ Weight _____

Social Security Number _____

E-mail _____

Person Who Referred You to Me _____ Marital S M W D

Children Sex & Ages _____

Occupation _____

Thank you for choosing me as your nutritionist. In the interest of building a strong and effective relationship that meets both our needs, please take a moment to read the information outlined here.

Insurance does not normally cover nutritional counseling or natural supplements, and further, because I am not a medical doctor, it is not legal for me to provide diagnosis codes to meet insurance needs. For this reason, it is important that you plan on paying for your phone consultation by credit card. Appointment fees are billed at \$100/hour pro-rated. This means that an appointment longer than 60 minutes will have a total charge more than the hourly rate and an appointment less than 60 minutes will have a total charge less than the hourly rate.

Follow-up questions are important and necessary for your success with the nutritional counseling process. For this reason, follow-up e-mail services are available at a reduced rate of \$15 per e-mail or pre-paid at a further savings of \$50 for 5 e-mails.

Please cancel appointments no later than 48 business hours in advance. Foregoing emergencies, you will be billed \$100 for appointments that are not canceled in that time frame.

Often I will recommend natural supplements as part of your wellness program. I dedicate myself to the ongoing research that is necessary to recommend the best quality products that are best suited to your unique biochemical needs. And because these high quality products are not readily available in health food stores, I have made special arrangements for you to be able to order these products directly from the company. I will give you the necessary information for ordering these products during your appointment.

As you know, nutritional counseling does not replace the care of your physician(s) and of course, I am not a medical doctor and cannot diagnose or treat disease. However, as a Certified Nutritionist*, I am very eager to work with you to help you reach your own health and wellness goals.

Please sign here to indicate that you understand the above statements and to request that Sherry Dell perform a nutritional evaluation for you for the purpose of recommending possible holistic diet and nutritional supplements to help you enhance your overall wellbeing. Thank you!

Name Date

MAJOR HEALTH CONCERNS

Please list your 5 major health concerns in order of importance.

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

ENERGY

1. Circle the number that describes your energy. Low 1 2 3 4 5 6 7 8 9 10 High
2. Does your energy fluctuate? _____
3. What time of the day do you feel the most energy? _____
4. What time of the day do you feel the least energy? _____
5. Do you wake up tired? _____

* Sherry received her CN in 1995 from the National Institute of Nutritional Education in Denver. She also holds a PhD from the University of Denver in Human Communication and a PhD in Holistic Health Science and Nutrition from Westbrook University. Additionally, she has studied privately with natural health practitioners from around the globe for the past 15 years. She is not a licensed medical practitioner. You can read more about her background at www.SherryDell.com.

APPETITE

- 1. Do you have a good appetite? _____
- 2. Do you eat when you're hungry? _____
- 3. Do you crave food frequently? _____
- 4. What kinds of food do you crave? _____

SLEEP

- 1. Describe sleep behavior (easy/hard falling asleep, restless, wake up at certain times, etc.)

- 2. Time to bed _____
- 3. Time to wake _____

- 4. Do you dream? _____

- 5. Do you remember your dreams? _____

- 6. Do you dream in black & white or color? _____

- 7. Any recurrent or frequent dreams? _____ Explain:

FAMILY HISTORY

1. What major diseases do your blood relations have currently, have had in the past, or have died from (include accidental deaths/suicides). Use these abbreviations: arthritis (AR), diabetes (D), cancer (CA), mental illness (MI), heart disease (HD), obesity (O), Chrones's disease (CD), multiple sclerosis (MS), osteoporosis (OS), tuberculosis (TB), blindness (B), deafness (DF), epilepsy (EP), suicide (S), emphysema (EM), asthma (AS)

Maternal grandmother _____ Sisters _____

Maternal grandfather _____

Paternal grandmother _____ Brothers _____

Paternal grandfather _____

Mother _____ Aunts _____

Father _____ Uncles _____

YOUR HEALTH IN THE PAST

1. Do you have a history of antibiotic use? _____ When? _____

2. Any diagnosed disease? _____

3. Any surgeries at any time in your life? _____ What kind and when?

4. Any accidents/physical traumas in your life? What and when?

5. Any emotional traumas in your life? What and when?

6. Any childhood diseases or health difficulties? What kind?

TRAVEL

1. Do you travel often? _____

2. Where and when? _____

TEETH

1. Do you have metal/amalgam fillings? _____ How many? _____

2. Do you have root canals? _____ How many? _____

3. Do you have bridges? _____ How many? _____

4. Do you have dentures? _____ Full or partial? _____

5. Do you gums bleed ? _____ Do you have receding gums? _____

6. Any other dental information: _____

PRACTITIONER CHOICES

List any other health practitioners (MD, DO, chiropractor, massage therapist, counselor, acupuncturist, homeopath, nutritionist, naturopath, etc.) that you work with.

BOWEL FUNCTION

1. Number of bowel movements per day _____

2. Time of bowel movements _____

3. Color: brown _____ black _____ yellow _____ bloody _____ white _____ other _____

4. Consistency (mark all that apply): hard _____ dry _____ medium _____ soft _____ loose/poorly

formed _____ diarrhea _____ alternating constipation and diarrhea _____

difficulty/straining passing stool _____ undigested food particles _____

URINE FLOW

1. Frequency _____ 2. Color _____ 3. Odor _____

4. Force of flow: normal _____ scanty _____ broken _____ dribble _____

5. Do you wake from sleep to urinate? _____ How many times per night? _____

LIFESTYLE

1. Do you exercise? _____ How often? _____ What kind? _____

2. Are you exposed to sunlight each day? _____ How much? _____

3. Do you smoke? _____ For how long? _____ How many cigarettes/day _____

When did you stop? _____

4. Do you drink alcohol? _____ How often? _____ How much? _____

What kind? _____ Since when? _____ Did you ever? _____

When did you stop? _____

5. Do you use recreational drugs? _____ What kind? _____

How often? _____ Did you ever? _____ When did you stop? _____

6. Do you drink city tap water? _____ Distilled water? _____ Purified water? _____

Carbonated water? _____ How many cups/day? _____

7. Are you exposed to cigarette smoke, solvents, fumes, x-ray, chemicals at your home or work? _____

Describe:

8. Please rate your stress level on a scale of 1-10; 10 is highest. _____

9. Is this stress ongoing, long-term, or very recent? _____

FOODS

1. How many times do you eat out per week? _____

2. How many times per week do you eat fish? _____

3. How many caffeinated beverages (coffee, tea, chocolate) do you drink per day? _____

4. List the three least healthy foods you eat during the average week _____

5. List the three healthiest foods you eat during the average week. _____

6. Do you eat breakfast? _____ How often? _____ Time? _____ Where? _____

Describe your last breakfast in detail:

7. Do you eat lunch? _____ How often? _____ Time? _____ Where? _____

Describe your last lunch in detail:

8. Do you eat supper? _____ How often? _____ Time? _____ Where? _____

Describe your last supper in detail:

9. Do you eat snacks? _____ How often? _____ Time? _____ Where? _____

Describe the snacks you ate yesterday in detail:

10. What beverages do you drink daily and how much volume?

SUPPLEMENTS AND MEDICATIONS

Please list all vitamins, supplements, and medications that you are currently taking. Include brand name, ingredients, and dose as you are able:

METABOLIC ASSESSMENT*

Please circle the appropriate number on each line below. 0 means the least/never. 3 means the most/always.

Category I: Colon

Feeling that bowels do not empty completely 0 1 2 3
Lower abdominal pain relief by passing stool or gas 0 1 2 3
Alternating constipation and diarrhea 0 1 2 3
Diarrhea 0 1 2 3
Constipation 0 1 2 3
Hard dry or small stool 0 1 2 3
Coated tongue of “fuzzy” debris on tongue 0 1 2 3
Pass large amount of foul smelling gas 0 1 2 3
More than 3 bowel movements daily 0 1 2 3
Do you use laxatives frequently 0 1 2 3

Category II: Hypochloridia

Excessive belching burping or bloating 0 1 2 3
Gas immediately following a meal 0 1 2 3
Offensive breath 0 1 2 3
Difficult bowel movements 0 1 2 3
Sense of fullness during and after meals 0 1 2 3
Difficulty digesting fruits and vegetables;
undigested foods found in stools 0 1 2 3

Category III: Hyperacidity (Ulcer)

Stomach pain, burning/aching 1-4 hours after eating 0 1 2 3
Do you frequently use antacids 0 1 2 3
Feeling hungry an hour or two after eating 0 1 2 3
Heartburn when lying down or bending forward 0 1 2 3
Temporary relief from antacids, food,
milk, carbonated beverages 0 1 2 3
Digestive problems subside with rest and relaxation 0 1 2 3
Heartburn due to spicy foods, chocolate, citrus,
peppers, alcohol and caffeine 0 1 2 3

Category IV: Small Intestine (Pancreas)

Roughage and fiber cause constipation 0 1 2 3
Indigestion and fullness lasts 2-4
hours after eating 0 1 2 3
Pain, tenderness, soreness on left side
under rib cage bloated 0 1 2 3
Excessive passage of gas 0 1 2 3

Nausea and/or vomiting 0 1 2 3
Excessive passage of gas 0 1 2 3
Stool undigested, foul smelling,
mucous-like, greasy or poorly formed 0 1 2 3
Frequent urination 0 1 2 3
Increased thirst and appetite 0 1 2 3
Difficulty losing weight 0 1 2 3

Category V: Biliary Insufficiency/Stasis

Greasy or high fat foods cause distress 0 1 2 3
Lower bowel gas and or bloating
several hours after eating 0 1 2 3
Bitter metallic taste in mouth,
especially in the morning 0 1 2 3
Unexplained itchy skin 0 1 2 3
Yellowish cast to eyes 0 1 2 3
Stool color alternates from clay colored
to normal brown 0 1 2 3
Reddened skin, especially palms 0 1 2 3
Dry or flaky skin and/or hair 0 1 2 3
History of gallbladder attacks or stones 0 1 2 3
Have you had your gallbladder removed Yes No

Category VI: Hypoglycemia

Crave sweets during the day 0 1 2 3
Irritable if meals are missed 0 1 2 3
Depend on coffee to keep yourself going or started 0 1 2 3
Get lightheaded if meals are missed 0 1 2 3
Eating relieves fatigue 0 1 2 3
Feel shaky, jittery, tremors 0 1 2 3
Agitated, easily upset, nervous 0 1 2 3
Poor memory, forgetful 0 1 2 3
Blurred vision 0 1 2 3

Category VII: Insulin Resistance

Fatigue after meals 0 1 2 3
Crave sweets during the day 0 1 2 3
Eating sweets does not relieve cravings for sugar 0 1 2 3
Must have sweets after meals 0 1 2 3

* developed by Datis Kharrazian, DC

Waist girth is equal or larger than hip girth **0 1 2 3**
Frequent urination **0 1 2 3**
Increased thirst & appetite **0 1 2 3**
Difficulty losing weight **0 1 2 3**

Category VIII: Adrenal Hypofunction

Cannot stay asleep **0 1 2 3**
Crave salt **0 1 2 3**
Slow starter in the morning **0 1 2 3**
Afternoon fatigue **0 1 2 3**
Dizziness when standing up quickly **0 1 2 3**
Afternoon headaches **0 1 2 3**
Headaches with exertion or stress **0 1 2 3**
Weak nails **0 1 2 3**

Category IX: Adrenal Hyperfunction

Cannot fall asleep **0 1 2 3**
Perspire easily **0 1 2 3**
Under high amounts of stress **0 1 2 3**
Weight gain when under stress **0 1 2 3**
Wake up tired even after 6 or more hours of sleep **0 1 2 3**
Excessive perspiration or perspiration with little or no activity **0 1 2 3**

Category X: Hypothyroid

Tired, sluggish **0 1 2 3**
Feel cold – hands, feet, all over . **0 1 2 3**
Require excessive amounts of sleep to function properly **0 1 2 3**
Increase in weight gain even with low-calorie diet **0 1 2 3**
Gain weight easily **0 1 2 3**
Difficult, infrequent bowel movements **0 1 2 3**
Depression, lack of motivation **0 1 2 3**
Morning headaches that wear off as the day progresses **0 1 2 3**
Outer third of eyebrow thins **0 1 2 3**
Thinning of hair on scalp, face or genitals or excessive falling hair **0 1 2 3**
Dryness of skin and/or scalp **0 1 2 3**
Mental sluggishness **0 1 2 3**

Category XI: Thyroid Hyperfunction

Heart palpations **0 1 2 3**

Inward trembling **0 1 2 3**
Increased pulse even at rest **0 1 2 3**
Nervous and emotional **0 1 2 3**
Insomnia **0 1 2 3**
Night sweats **0 1 2 3**
Difficulty gaining weight **0 1 2 3**

Category XII: Pituitary Hypofunction

Diminished sex drive **0 1 2 3**
Menstrual disorders or lack of menstruation **0 1 2 3**
Increased ability to eat sugars without symptoms **0 1 2 3**

Category XIII: Pituitary Hyperfunction

Increased sex drive **0 1 2 3**
Tolerance to sugars reduced **0 1 2 3**
“Splitting” type headaches **0 1 2 3**

Category XIV (Men Only): Prostate

Urination difficulty or dribbling **0 1 2 3**
Urination frequent **0 1 2 3**
Pain inside of legs or heels **0 1 2 3**
Feeling of incomplete bowel evacuation **0 1 2 3**
Leg nervousness at night **0 1 2 3**

Category XV (Men Only): Andropause

Decrease in libido **0 1 2 3**
Decrease in spontaneous morning erections **0 1 2 3**
Decrease in fullness of erections **0 1 2 3**
Difficulty in maintain morning erections **0 1 2 3**
Spells of mental fatigue **0 1 2 3**
Inability to concentrate **0 1 2 3**
Episodes of depression **0 1 2 3**
Muscle soreness **0 1 2 3**
Decrease in physical stamina **0 1 2 3**
Unexplained weight gain **0 1 2 3**
Increase in fat distribution around chest and hips **0 1 2 3**
Sweating attacks **0 1 2 3**
More emotional than in the past **0 1 2 3**

Category XVI (Menstruating Women Only)

Are you perimenopausal **Yes No**
Alternating menstrual cycle lengths **Yes No**
Extended menstrual cycle, greater than 32 days **Yes No**

Shortened menses, less than every 24 days **Yes No**
Pain and cramping during periods **0 1 2 3**
Scanty blood flow **0 1 2 3**
Heavy blood flow **0 1 2 3**
Breast pain and swelling during menses **0 1 2 3**
Pelvic pain during menses **0 1 2 3**
Irritable and depressed during menses **0 1 2 3**
Acne break outs **0 1 2 3**
Facial hair growth **0 1 2 3**
Hair loss/thinning **0 1 2 3**

Category XVII (Menopausal Women Only)

How many years have you been menopausal? _____
Do you ever have uterine bleeding since menopause? **Yes No**
Hot flashes **0 1 2 3**
Mental fogginess **0 1 2 3**
Disinterest in sex **0 1 2 3**
Mood swings **0 1 2 3**
Depression **0 1 2 3**
Painful intercourse **0 1 2 3**
Shrinking breasts **0 1 2 3**
Facial hair growth **0 1 2 3**
Acne **0 1 2 3**
Increased vaginal pain, dryness or itching **0 1 2 3**