

*Bonnie Fisk-Hayden, MS*

Tel. & Fax. 415 663-8411

NUTRITIONAL CONSULTANT

P.O. Box 696 Point Reyes Station CA 94956

Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home phone \_\_\_\_\_ Work phone \_\_\_\_\_ Cell \_\_\_\_\_

Email \_\_\_\_\_

Birth Date \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Reason for Consultation and/or goals: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Any current medical diagnoses: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Do you smoke? \_\_\_\_\_ Drink alcohol? \_\_\_\_\_ How much/when? \_\_\_\_\_

Do you drink caffeine? \_\_\_\_\_ How much/when? \_\_\_\_\_

Do you overeat? \_\_\_\_\_ If so, which foods and how often? \_\_\_\_\_

\_\_\_\_\_

Do you have food allergies or sensitivities? \_\_\_\_\_

Describe your daily energy levels \_\_\_\_\_

\_\_\_\_\_

Do you get noticeably irritable, light-headed, or weak if you have not eaten in a while? \_\_\_\_\_

Do you crave any of the following? \_\_\_ Sugar \_\_\_ Meat Fat \_\_\_ Chocolate

\_\_\_ Fish \_\_\_ Alcohol \_\_\_ Desserts \_\_\_ Milk/cheese \_\_\_ Bread \_\_\_ Fried Foods

Other \_\_\_\_\_

Do you take nutritional supplements? \_\_\_\_\_ If so, which ones? (be specific; attach extra sheets if necessary)

\_\_\_\_\_

\_\_\_\_\_

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List any prescription or over-the-counter meds you take regularly and for what conditions: \_\_\_\_\_

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Which oils do you consume?  Butter  Peanut  Canola  Margarine  Corn  
 Sun/Safflower  Olive  Crisco  Vegetable  Coconut  Mayonnaise  
 Flax  Soybean Other \_\_\_\_\_

How often do you move your bowels? Any particular problems? \_\_\_\_\_

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Rank your skin without lotion:  Oily  Normal  Dry  Very Dry  Combination

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**PLEASE CHECK ANY OF THE FOLLOWING THAT MAY PERTAIN TO YOU (PAST OR PRESENT)**

- |                                                               |                                                        |                                                       |
|---------------------------------------------------------------|--------------------------------------------------------|-------------------------------------------------------|
| <input type="checkbox"/> Acne                                 | <input type="checkbox"/> Diabetes Type II              | <input type="checkbox"/> Insomnia                     |
| <input type="checkbox"/> Addictions (alcohol/drugs/<br>foods) | <input type="checkbox"/> Diarrhea                      | <input type="checkbox"/> Intestinal problems          |
| <input type="checkbox"/> Anemia                               | <input type="checkbox"/> Difficulty losing weight      | <input type="checkbox"/> Kidney stones                |
| <input type="checkbox"/> Anorexia                             | <input type="checkbox"/> Difficulty gaining weight     | <input type="checkbox"/> Liver problems               |
| <input type="checkbox"/> Anxiety or nervousness               | <input type="checkbox"/> Emotional problems            | <input type="checkbox"/> Loose stools                 |
| <input type="checkbox"/> Amalgam (silver) fillings #_____     | <input type="checkbox"/> Emphysema                     | <input type="checkbox"/> Memory loss or confusion     |
| <input type="checkbox"/> Arthritis                            | <input type="checkbox"/> Fainting                      | <input type="checkbox"/> Nails, poor growth/splitting |
| <input type="checkbox"/> Bladder infections                   | <input type="checkbox"/> Gall bladder problems         | <input type="checkbox"/> Panic attacks                |
| <input type="checkbox"/> Bloating, gas, indigestion           | <input type="checkbox"/> Gout                          | <input type="checkbox"/> Parasites                    |
| <input type="checkbox"/> Blood Sugar problems                 | <input type="checkbox"/> Hair loss or poor hair growth | <input type="checkbox"/> Pregnant or nursing          |
| <input type="checkbox"/> Bronchitis                           | <input type="checkbox"/> Headaches                     | <input type="checkbox"/> Respiratory problems         |
| <input type="checkbox"/> Cancer                               | <input type="checkbox"/> Heart disease                 | <input type="checkbox"/> Ringing in ears              |
| <input type="checkbox"/> Colds/flu (frequent)                 | <input type="checkbox"/> Heartburn                     | <input type="checkbox"/> Seizures                     |
| <input type="checkbox"/> Cold sores                           | <input type="checkbox"/> Hemorrhoids                   | <input type="checkbox"/> Severe mood swings           |
| <input type="checkbox"/> Chronic Fatigue                      | <input type="checkbox"/> Herpes simplex or type II     | <input type="checkbox"/> Skin conditions              |
| <input type="checkbox"/> Constipation                         | <input type="checkbox"/> High blood pressure           | <input type="checkbox"/> Stroke                       |
| <input type="checkbox"/> Dandruff                             | <input type="checkbox"/> High cholesterol              | <input type="checkbox"/> Suicidal tendencies          |
| <input type="checkbox"/> Depression                           | <input type="checkbox"/> HIV                           | <input type="checkbox"/> Thyroid condition _____      |
| <input type="checkbox"/> Diabetes Type I (insulin-dep.)       | <input type="checkbox"/> Hot flashes                   | <input type="checkbox"/> Ulcer                        |
|                                                               | <input type="checkbox"/> Hypoglycemia                  | <input type="checkbox"/> Yeast infections             |

**WOMEN:** Check all that pertain

- PMS
- Irregular periods
- Painful periods
- Loss of periods
- Loss of libido
- Birth control pills
- Menopause
- Painful intercourse
- Children
- Hysterectomy

**MEN:** Check all that pertain

- Frequent urination
- Difficulty urinating
- Difficulty with erection
- Loss of libido
- Prostate enlargement
- Loss of energy or muscle strength

Please list any disease or ailments in your immediate family (ie. mother/breast cancer)

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Do you exercise? \_\_\_\_\_ If so, what kind? \_\_\_\_\_

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How often? \_\_\_\_\_ Since when? \_\_\_\_\_

Please rate the following:

- |                                    |                                    |                                 |                               |                                    |
|------------------------------------|------------------------------------|---------------------------------|-------------------------------|------------------------------------|
| <b>DAILY ENERGY LEVEL</b>          | <input type="checkbox"/> Excellent | <input type="checkbox"/> Good   | <input type="checkbox"/> Fair | <input type="checkbox"/> Poor      |
| <b>ENERGY LEVEL AFTER EXERCISE</b> | <input type="checkbox"/> Excellent | <input type="checkbox"/> Good   | <input type="checkbox"/> Fair | <input type="checkbox"/> Poor      |
| <b>DAILY STRESS LEVEL</b>          | <input type="checkbox"/> Low       | <input type="checkbox"/> Medium | <input type="checkbox"/> High | <input type="checkbox"/> Very High |
| <b>GENERAL ENJOYMENT OF LIFE</b>   | <input type="checkbox"/> Excellent | <input type="checkbox"/> Good   | <input type="checkbox"/> Fair | <input type="checkbox"/> Poor      |

How many hours do you sleep? \_\_\_\_\_ Do you sleep soundly? \_\_\_\_\_

Please describe any health concerns that you think are important \_\_\_\_\_

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By signing below, you acknowledge that any dietary or supplemental suggestions made by Bonnie Fisk-Hayden Nutritional Consultant are entirely nutritional in nature and are not intended as a diagnosis, cure, or treatment for any disease or ailment. You also acknowledge that your physician is your primary health care provider who is responsible for supervising all changes in diet and nutrient intake that you make.

Signed \_\_\_\_\_

Date \_\_\_\_\_

## THREE-DAY DIET RECALL

Record everything that you eat and drink. Be as specific as possible regarding time and size/amount of portion. Indicate how hungry you were and what you were doing while eating.

### DAY 1:

BREAKFAST \_\_\_\_\_

\_\_\_\_\_

MID-MORNING SNACK \_\_\_\_\_

LUNCH \_\_\_\_\_

\_\_\_\_\_

AFTERNOON SNACK \_\_\_\_\_

DINNER \_\_\_\_\_

\_\_\_\_\_

AFTER-DINNER SNACK \_\_\_\_\_

### DAY 2:

BREAKFAST \_\_\_\_\_

\_\_\_\_\_

MID-MORNING SNACK \_\_\_\_\_

LUNCH \_\_\_\_\_

\_\_\_\_\_

AFTERNOON SNACK \_\_\_\_\_

DINNER \_\_\_\_\_

\_\_\_\_\_

AFTER-DINNER SNACK \_\_\_\_\_

### DAY 3:

BREAKFAST \_\_\_\_\_

\_\_\_\_\_

MID-MORNING SNACK \_\_\_\_\_

LUNCH \_\_\_\_\_

\_\_\_\_\_

AFTERNOON SNACK \_\_\_\_\_

DINNER \_\_\_\_\_

\_\_\_\_\_

AFTER-DINNER SNACK \_\_\_\_\_