New England
Naturopathic Health
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Nutrition Intake Paperwork

Today's Date: _____ Sex:_____

Full Legal Name: _____ Preferred Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Cell Phone:_____ Work Phone:_____ Home Phone:_____

Email: _____ Preferred Method of Contact: _____

Date of Birth:_____ Social Security Number: _____

Occupation: _____ Employer: _____

Whom to contact in case of emergency? (relation and contact number)_____

Briefly explain your reason for seeking nutrition support: _____

_____

_____

_____

_____

_____

Nutrition Habits

Has your doctor ever told you to follow a specific diet for medical reasons (examples: DASH diet, low fat diet, diabetic diet):_____
_____

Do you follow a special diet for religious or personal reasons (examples: vegetarian, Weight Watchers):_____
_____

Have you previously tried any other diets? If yes, what were the outcomes?_____
_____

What are your favorite meals:_____
_____

Food and nutritional goals:_____
_____
_____

Do you have Food Allergies/Sensitivities? What are your reactions? _____
_____
_____

Check all factors that apply to eating habits:

❑ Fast eater	❑ Erratic eater	❑ Emotional eater
❑ Snack throughout day	❑ After diner nibbler	❑ Late night eater
❑ Grazer	❑ Poor snack choices	❑ Live alone or often eat alone
❑ Love to cook	❑ Dislike cooking	❑ Don’t know how to cook
❑ Love to eat	❑ Eat because I have to	❑ Eat too much
❑ Rely on convenience items	❑ Eat fast food frequently	❑ Travel Frequently
❑ Do not plan meals/menus	❑ Lack of time to prepare meals	❑ Work schedule difficulties
❑ Multiple Family Preferences	❑ Feed family then myself	❑ Confused about nutrition
❑ Eat to look good	❑ Eat to be healthy	❑ Eat for athletic performance
❑ Visual / Textural Eater	❑ Negative relationship to food	❑ Dislike “healthy” food
❑ Lack money to buy desired foodz	❑ Lack of support from relatives/friends/coworkers	❑ Family member(s) have different dietary need

Daily Intake Summary

Who prepares the majority of your meals: _____ If you, how much time is spent preparing meals:_____

Who shops for food? _____ Where do you shop?_____

How many meals do you eat in a day: _____ How many snacks in a day:_____

What type(s) of protein do you regularly consume (check all that apply):

❑ Beef, pork, poultry ❑Wild Game ❑ Fish and Seafood ❑ Beans ❑ Eggs ❑ Soy-based ❑ Dairy ❑ Nuts and Seeds

Servings of Fruit in a day: _____ Servings of Vegetables in a day: _____

How much water do you drink in a day: _____ Caffeine: _____

Other beverages: _____

Do you drink alcohol: yes no if yes, servings per week: Beer _____ Wine _____ Liquor _____

Do you use Tobacco products (circle one): Never Former Current if yes, select type: Vaping Dip Cigarette Cigars

Do you use Marjuana products Type: edibles smoke any other recreational drugs:_____

How many meals a week do you eat that are prepared outside the home? ❑ 0-3 ❑ 4-7 ❑ 7-10 ❑ 10-14 ❑ 14+

24 hour Meal Recall - please list what you ate yesterday:

Breakfast

Lunch

Dinner

Snacks

Food Frequency Questionnaire

Please indicate how regularly you eat each of the listed foods:

Foods	Never / Rarely	Monthly	Weekly	2-3 times Weekly	4-6 times weekly	Daily
Fast Food						
Restaurant Food						
Pre Packaged Meals						
Frozen Meals						
Red Meat						
Pork						
Poultry (chicken, turkey, duck)						
Processed Meat (deli meat, sausages, hot dogs etc)						
Cold Water Fish (salmon, cod, haddock, sardines, ect)						
Other Fish or Seafood (snapper, shrimp, mussels,etc)						
Beans, Legumes (kidney beans, lentils, peanuts, ect)						
Nuts and Seeds (almond, cashew, sunflower, chia, etc)						
Soy and Soy Products - Tofu, Tempeh						
Eggs						
Green Leafy Vegetables (kale, lettuce, romaine, etc)						
White/Tan Fruits and Vegetables (banana, potato, onion, etc)						
Yellow Fruits and Vegetables (corn, pineapple, lemon, etc)						
Orange Fruits and Vegetables (orange, sweet potato, pumpkin, etc)						
Red Fruits and Vegetables (strawberry, tomato, beets, etc)						
Blue/Purple Fruits and Vegetables (blackberry, eggplant, plum, etc)						
Other Green Fruits and Vegetables (avocado, broccoli, peas, etc)						
Cheese						
Yogurt, Kefir, Sour cream						
Cow’s milk						
Baked Goods (Bread, bagel, muffin)						
Baked Goods (pastries, cookies, brownies)						
Candy						
Artificial Sweeteners						

Goals And Readiness Assessment

On a scale of 1 (not ready) to 5 (very ready), please indicate where you are for the following:

To improve your health, would you...	1	2	3	4	5
Make significant changes to your diet					
Change food hygiene (where and how you eat, triggers)					
Monitor intake with food diary or measure food servings					
Modify your schedule/lifestyle (sleep habits, dinner time)					

What does your ideal diet look like:_____
_____
_____

If I could change three things about my nutrition, they would be:

1. _____
2. _____
3. _____

Challenge(s) to reaching nutrition goals:_____
_____

I would like to learn more about (check all that apply):

❑ Label Reading

❑ Special Diets

❑ Healthy eating out skills

❑ Increasing fiber

❑ Cholesterol / Lipid Reduction

❑ Recipes to disguise certain foods

❑ Gluten-free alternatives

❑ Dairy alternatives

❑ Protein alternatives

❑ Grocery shopping

❑ Help eliminating foods

❑ Meal planning

❑ Increasing fruits and vegetables

❑ Blood sugar reduction

❑ Different ways to eat foods

❑ Grain-free alternatives

❑ Cheese alternatives

❑ Whole grains

Personal Medical History

Who is your Primary Care Physician/Home (name and title)?_____

Please list any previous injuries, surgeries, and hospitalization: _____
_____

Medication/Supplement	Year Started	Dose	Frequency	Reason

Do you have any problems sleeping? How many hours do you typically sleep in a night?_____
_____

Do you exercise? Please list types and amounts per week:_____
_____

Indicate your daily stressors and rate level of stress from 1 (extremely low) to 10 (extremely high)
❑ Work_____ ❑ Family_____ ❑ Social_____ ❑ Financial_____ ❑ Health_____ ❑ Other_____

Digestive Health: please indicate how often the following occurs for you

Do you have a daily bowel movement: yes no
How often do you have constipation? never/rarely monthly weekly daily
Do you regularly use laxative? If yes, please state type and how often:_____
How often do you have diarrhea? never/rarely monthly weekly daily
Can you see pieces of undigested food in your stool? Yes no

Check any illnesses or conditions that you have or have previously experienced

❑ Alcoholism/Drug Use
❑ Anxiety
❑ Arthritis
❑ Autoimmune Disease: _____
❑ Breathing problems
❑ Cancer, list type: _____
❑ Cardiovascular Disease
❑ Celiac Disease / other gluten condition
❑ Depression
❑ Eating Disorder: _____
❑ GERD, reflux / heartburn
❑ Gout
❑ High Blood Lipids / Cholesterol
❑ High Blood sugar / Diabetes
❑ Infertility
❑ Inflammatory Bowel Disease: _____
❑ Irritable Bowel Syndrome / SIBO
❑ Kidney Disease
❑ Kidney Stones
❑ Liver problems
❑ Osteoporosis
❑ Stroke
❑ Thyroid problems
❑ Other: _____

New England Naturopathic Health Policies

Please initial the following statements:

☐ I understand that nutrition office visits are not medical office visits and only nutrition and/or nutrition-related subjects will be discussed during the nutrition visit.

☐ I understand that nutrition counseling does not guarantee weight loss.

☐ I understand that payment of consultation fees, lab fees, supplements and any other services are due at the time of service.

☐ I understand that phone consultations and phone lab reviews with Dr. Froman will be billed at the same rate as an in-office visit.

☐ I understand that I may message Dr. Froman's support staff through the Charm Portal. Email is not an acceptable communication format due to confidentiality concerns.

☐ I understand that any supplements purchased at NENH or via Fullscript / Wellevate (per NENH request) cannot be returned once opened.

☐ I understand that if I am more than ten minutes late for an appointment. I may not be seen and may be charged a cancellation fee.

☐ I understand that should I miss an appointment or cancel with less than a twenty-four hours' notice, I will be assessed a cancellation fee.

☐ I understand it is my responsibility for payment on all nutritional visits, and that if requested I can receive a superbill to directly submit to my insurance company.

☐ I understand that Naturopathic doctors in the state of Maine serve as specialists and not primary care doctors. For this reason, I understand that it is my responsibility to have a PCP, or to be actively looking to establish care with a PCP, prior to establishing care at New England Naturopathic Health.

Terms of Consent for Care

I, _____, hereby authorize Dr. Froman to perform the following specific procedures as necessary to facilitate nutrition guidance:

Nutritional diagnostic procedures: e.g., venipuncture for food sensitivity test

Medical use of nutrition: therapeutic nutrition, nutritional supplementation, and intramuscular vitamin injections.

Botanical medicine: plant substances may be prescribed as teas, alcohol-based tinctures, glycerites, capsules, tablets, creams or suppositories

Nutritional Counseling Techniques: utilization of nutritional counseling and techniques such as Motivational Interviewing, stress-reduction techniques, mindful meditation

I recognize the potential risk and benefits of these procedures as described below:

Potential risks: allergic reactions to prescribed herbs and supplements, side effects of medications or vaccinations, aggravation of pre-existing symptoms, discomfort, pain, infection, burns, nausea, lightheadedness, inconvenience of lifestyle changes, injury from injections, venipuncture or procedures. Please notify Dr. Froman if you experience any symptoms which may be secondary to the above procedures.

Potential benefits: restoration of health and the body's maximal functional capacity without the use of drugs or surgery, relief of pain and symptoms of disease, assistance in injury and disease recovery, and prevention of disease or it's progression.

Notice to Pregnant Women: All female patients **must alert** the doctor if they know or suspect that they are pregnant as some of the therapies used could present a risk to the pregnancy.

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by the naturopathic doctor, or any personnel regarding cure or improvement of my condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by myself or my representative or unless it is required by law. I understand that I may look at my medical record at any time and can request a copy of it by paying the appropriate fee. I understand that my medical record will be kept for a minimum of seven years, but no more than ten years after the last day of my visit. I understand that information from my medical record may be analyzed for research purposes, and that my identity will be protected and kept confidential. I understand that any questions I have will be answered by my practitioner to the best of his/her ability.

I understand that all sales of goods and services are final. Refunds for supplements are available up to 90 days after purchase (unopened items only).

I understand that nutrition office visits are not medical visits. If I wish to discuss medical needs not related to nutrition, I understand that I must schedule either a new patient consultation or medical follow-up visit.

Signature of Patient: Date: