For Men
Dr. Sonia's Food Wisdom/Therapy

Complementary Health an Art of SelfHealing

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REGISTERED DIETITIAN #: 580080

Your response to the following questions will empower you and me to design a personalized lifetime approach for a healing plan that will meet your needs for an complementary , natural approach to the physical, biological and psychological changes that affect you.

Today's Date: _____ Gender F ❒ M ❒
Name:_____ Birth Place_____
Address: _____
Home phone_____ Work #_____fax or email_____
Date of Birth_____19___ Social Security #_____
occupation_____ Education_____

Employer name, address and telephone_____phone
_____
Insurance Companies_____

Referring doctor or if any_____ phone:_____
Address_____

Highest level of education _____ Occupation _____

Marital Status; ❒ Married ❒ Single ❒ Long term significant relationship
Number of children____
Persons who live with you and socieconomic status

Please indicate which group most closely describes you

a. Asian or pacific Island
b. Hispanic (including Mexican-American and others)
c. Black
d. Middle Eastern
e. European

f. White
g. Other_____
Did you live in any other country previously?_____
Parents's type of profession and socio-economic status, their relationship with you
Your hobby, special passions or strong interests

Anthropometric measurements*:*
Current Weight _____lbs. Height ____ Hip___Chest ____
Waist____ Thighs Triceps ____ % frame: Sml ❒ Med ❒ Lrg ❒
Body Fat %_____ Electrolyte % Muscle Mass___ and Fat in lbs___
What is your desirable or healthy weigth?_____
How long have you been at your current weight ?_____
How many pounds do you want to lose _____ or to gain weekly ____
List the previous weight or eating disorder programs and what was the result?
_____
What do you think are the causes of your weight problem?_____
_____

PERSONAL MEDICAL/NUTRITIONAL HISTORY AND DATA

Chief Health Concerns or Complains

Long Term Health Concerns

Any Treatments for above Concerns

Do you have any nutritional problem? Yes___ No____
If yes, What?_____

Any nutritional problem you consider have had in your childhood to the present time.

*What **medication** (s) do you take?_____*
Laboratory test result & date if known or you may rate on **High Low and Normal**
FSH____Estrogen_____Progesterone____ DHEA___ Glucose ____
Choles_____ LDL_____ HDL____ Bone Density_____
Other Mineral or Vitamins deficiency _____
Have you ever tested for Toxicity, intestinal parasites, and candida if yes, indicate the result.

Family Medical History
-- check below if immediate family members have had:

Cancer_____ what type?_____ Heart disease _____ Hypertension_____
Osteoporosis ____ Diabetes _____ Hypoglycemia_____Obesity ____
Depression _____ or other mental illness_____
Addiction_____ Allergies _____ Asthma_____
Autoimmune problems (thyroid, lupus, rheumatoid arthritis, etc.) _____
other_____
Please show current ages of family mentioned above or age at death_____

Please indicate how any of the following concerns or symptoms apply to you currently: rate symptoms or concerns on a scale of 0(no symptom) to 5 (very symptomatic).

Worry about aging? _____ Worry about gaining weight? ____ Feeling fatigue? ___ Feeling low energy? ___ Tiredness ?____ Craving for sweets? ____Joint pain? ____ Constipation?____ Experience bloating or gas?___ Feeling indigestion? ___ Difficulty of breathing?___ Loss of appetite? ____ Night sweating? ____ Difficulty sleeping?___ Waking up tired? ___ Interrupted sleep?___ Bad dreams ?___ Low mental concentration?___ Forgetfulness ?__ Fuzzy thinking ?___ Moodiness ?___ Frustrated? ___ Misplaced anger? ___ Anxiety ?___ Depression? ___ Skin, nail or hair dryness?__ Hair lost? ___ Skin tingling & burning?__ Acne ? ___ Skin rashes ?___Eyes red &/or blurred ?__ Dental or gum problem?__ Canker sore?___ Heartburn ?___ Headaches ?___ Frequent urination? ___ Decrease in sexual desire? ____ Fear of colon cancer?__ Fear of breast cancer? __ Fear of heart disease?___ Fear of stroke? ___Fear of getting osteoporosis?

YOUR SPIRITUAL /BELIEFS/FEARS/INTUITION SYSTEM?

Please mark the level of your happiness and stress
Rate stress on a scale of 0(not stressful) to 10(very stressful) with Job___ and or lifestyle __
Rate happiness on a scale of 0 (not happy) to 10 (very happy) with Job___ and/or lifestyle __

YOUR FUTURE LIFESTYLE

What is your overall evaluation of your energy and health?

Do you smoke or have you smoked in the past? *Yes____ No_____*
If yes, for how long?_____ How many cigarettes per day?_____
If stopped, when did you stop?_____

Do you drink alcohol? *Yes____ No_____*
If yes, less than 2 drinks per day?____ more than 2 drinks per day_____

Do you exercise regularly?
If yes, for how long_____how frequently? _____ *Yes____ No____*
what type?_____ how strenuously? _____

Do you practice meditation? *Yes___ No_____*
If yes, for how long____how frequently? _____what type?_____

YOUR HEALING GOALS

Do you take vitamins, minerals, enzyme or other supplements? Yes____ No____
If yes, please list_____

Do you take herbs? If so, please indicate their name and reason for taking
_____
Are you allergic or sensitivities to any foods? Please list _____
_____
Any food that you can not tolerate or digest?_____

Do you consider your diet *good____* *avg___* *poor____*

Describe why you have so classified your diet

Do you regularly skip any meals? No___Yes ___if yes, which ones?____
Do you snack during the day? No___ Yes ____ if yes, what time (s) of day?
What do you do to try to control your weight?

If you want to change your diet, what changes do you believe need to be made?

How frequently do you consume below foods?
Please check the following:
for daily (D) for 2 times per week (W) for often (O) for never (N)

milk ___ cheese_____ yogurt_____ red meat_____ poultry____
fish_____ eggs_____ legumes/beans_____ tofu___nuts/seeds_____
grains___rice____pasta____ fruits ____vegetables____ greens/ herbs _____
Any additional comments you would like to offer?

Email completed questionnaire to Dr. Sonia at:

drsonia@msn.com

or Mail to:

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