



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 socioeconomic 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 weight? _____

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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