THE BERKLEY CENTER
for Reproductive Wellness

16 East 40th Street ▪ 2nd Floor ▪ New York NY 10016 ▪ 877.965.BABY ▪ berkleycenter.com

INITIAL NUTRITION EVALUATION

So that we can spend our time together efficiently, please
RETURN THIS FORM **2** DAYS BEFORE YOUR APPOINTMENT

Full Name: ____________________

Address: ____________________

City, State and Zip: ____________________

Phone numbers: Home: ____________________

Cell: ____________________

Email: ____________________

	YOURSELF	YOUR PARTNER
Height		
Current weight		
Weight at 20 years of age		
Current Age		
List 3 foods you enjoyed eating this week:		
List 3 foods you dislike:		
List vitamins, minerals and other supplements you are taking with brand names if you can:		
List current medications:		

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	YOURSELF	YOUR PARTNER
How many times per week do you have:	Breakfast ____ times/wk Lunch ____ times/wk Supper ____ times/wk	Breakfast ____ times/wk Lunch ____ times/wk Supper ____ times/wk
Do you have any of these?		
Diabetes	Yes / No	Yes / No
PCOS	Yes / No	Yes / No
Thyroid disorder	Yes / No	Yes / No
High blood pressure	Yes / No	Yes / No
Bloating / Intestinal pain	Yes / No	Yes / No
Constipation	Yes / No	Yes / No
Gas / Belching	Yes / No	Yes / No
Celiac Disease	Yes / No	Yes / No
Diverticulitis	Yes / No	Yes / No
Chron's	Yes / No	Yes / No
Heart Disease	Yes / No	Yes / No
High Cholesterol	Yes / No	Yes / No
Hemorrhoids/ Piles	Yes / No	Yes / No
Candida in the last 6 mths	Yes / No	Yes / No
Urinary infection recently	Yes / No	Yes / No
Stuffy nose, Sinus problems,	Yes / No	Yes / No
Excess mucus, hay fever	Yes / No	Yes / No
Overweight/Obesity	Yes / No	Yes / No
Dry/sensitive skin	Yes / No	Yes / No
Itchy skin/scalp	Yes / No	Yes / No
Fatigue/lack of energy	Yes / No	Yes / No
Wake up during the night	Yes / No	Yes / No
Tearful for no reason	Yes / No	Yes / No

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	YOURSELF	YOUR PARTNER
Tell me about your recent blood lab results:		
Do you crave salty foods?		
Do you crave sweet foods and drinks?		
How many times per week do you eat out or have take-out?	Breakfast ____ times/wk Lunch ____ times/wk Supper ____ times/wk	Breakfast ____ times/wk Lunch ____ times/wk Supper ____ times/wk
List food allergies:		
List 4 fruits / vegetables you could eat all the time:		
Do you like cooking?	Yes / No	Yes / No
How many hours per week do you work?		
What do you do to reduce stress?		
Do you smoke?	Yes / No	Yes / No

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	YOURSELF	YOUR PARTNER
How often do you exercise? (e.g. walk over 20 minutes, swim, jog, go to gym, active sports, aerobics class, yoga)	A few times / week A few times / month A few times / year Never	A few times / week A few times / month A few times / year Never
What diets have you tried so far?		
What are you reading on nutrition?		
A fertile healthy diet concerns more than food. How are you managing the emotional and spiritual aspects of living?		
List the groceries you purchased this week:		
List the regular items in your freezer and refrigerator:		

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	YOURSELF	YOUR PARTNER
Tell me about your typical day: what you ate and drank at what time, what you did:		

For Women

Do you menstruate regularly?

Describe your symptoms and mood before a period:

Describe your symptoms and mood during a period:

Describe any other concerns you have about food, therapies or nutrition programs you have tried:

As a new mother, what will you gain and what will you leave behind?

For Men

What do you think is the best part of being a new father?

Are you ready to change nutrition habits yourself? This is not a judgmental question but one to help assess with your lifestyle changes for both of you.

Nutritional Counseling Privacy Policy

Your personal information is protected and will not be disclosed to anyone without your written request. Please note that all of your information will be destroyed 18 months after your last appointment.

I understand the protection of my personal information as stated above.

____
Name (print)

____
Signature

____
Date