

## PERSONAL INFORMATION

Please fill out the following information for our records:

Date: \_\_\_\_\_

### Patient Information

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Daytime phone: \_\_\_\_\_

Home phone: \_\_\_\_\_

Cell phone: \_\_\_\_\_

E-mail address: \_\_\_\_\_

Profession: \_\_\_\_\_

How many hours/wk do you work? \_\_\_\_\_

Gender  Male  Female

Birth date: \_\_\_\_\_

Place of Birth: \_\_\_\_\_

Marital Status: Married  Single  Divorced

Widowed  # of children \_\_\_\_\_

### Emergency Contact Information

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Daytime phone: \_\_\_\_\_

Home phone: \_\_\_\_\_

Cell phone: \_\_\_\_\_

E-mail address: \_\_\_\_\_

Have you ever seen a Nutritional Counselor before?  Yes  No

If yes: When? \_\_\_\_\_ With whom? \_\_\_\_\_

How were you referred to The Berkley Center for Reproductive Wellness?

Friend \_\_\_\_\_ Relative \_\_\_\_\_ Seminar \_\_\_\_\_ Internet \_\_\_\_\_ Other \_\_\_\_\_

## MEDICAL HISTORY

Height \_\_\_\_\_ Weight (current) \_\_\_\_\_ Weight (6 months ago) \_\_\_\_\_ Weight (1 yr ago) \_\_\_\_\_

Would you like your weight to be different? \_\_\_\_\_

### Please indicate any significant illness you or blood relatives have had:

Illness	You	Your Relative	Approx. Date	Illness	You	Your Relative	Approx. Date
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	_____	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____	Seizures	<input type="checkbox"/>	<input type="checkbox"/>	_____
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	_____	Emotional Disorders	<input type="checkbox"/>	<input type="checkbox"/>	_____
Infectious Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	_____

### Have you ever had and Sexually Transmitted Diseases?

Gonorrhea       Syphilis       AIDS       HPV       Chlamydia       Herpes  
 Date \_\_\_\_\_      Date \_\_\_\_\_      Date \_\_\_\_\_      Date \_\_\_\_\_      Date \_\_\_\_\_      Date \_\_\_\_\_

### List any medications and vitamin supplements you are currently taking: (Continue on back of this page if necessary)

Medicine	Dosage	Reason	How long	Prescribed	Date of last Checkup

### Check the Box if any of the following statements is true:

- I have known allergies       I am taking Coumadin/Warfarin  
 I have a pacemaker       I am taking Lithium (Eskalith, Lithobid, Lithonate, Lithotabs)

**What are the main Health problems for which you are seeking treatment?**

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**What other forms of treatment have you sought?**

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**List any Health problems you now have.**

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**List any accidents, surgeries, or hospitalizations (include date).**

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**Lab results (please include copies).**

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**How do you FEEL about the following areas of your life?**

	Great	Good	Fair	Poor	Bad	Your comments
Significant Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<hr/>
Family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<hr/>
Diet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<hr/>
Sex	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<hr/>
Self	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<hr/>
Work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<hr/>
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<hr/>
Spirituality	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<hr/>

## FOR WOMEN

Age of 1<sup>st</sup> period (menarche) \_\_\_\_\_

Are you pregnant?  Yes  No # of pregnancies \_\_\_\_\_

Age of last period (menopause) \_\_\_\_\_

# of live births \_\_\_\_ # of abortions \_\_\_\_ # of miscarriages \_\_\_\_

Number of days between periods \_\_\_\_\_

Date of Last GYN exam \_\_\_\_\_ Date of last Pap smear \_\_\_\_\_

Number of days of flow \_\_\_\_\_

Mammogram \_\_\_\_\_ Bone Density Scan \_\_\_\_\_

Color of flow \_\_\_\_\_

Results \_\_\_\_\_

Clots?  Yes  No Color \_\_\_\_\_

Average number of pads you use per day: 1<sup>st</sup> day \_\_\_\_ 2<sup>nd</sup> day \_\_\_\_ 3<sup>rd</sup> day \_\_\_\_ 4<sup>th</sup> day \_\_\_\_ 5<sup>th</sup> day \_\_\_\_

Location of pain:  Lower abdomen  Lower back  Thighs  Other \_\_\_\_\_

### Please indicate the nature of pain and when experienced:

(N) = Never experienced; (PM) = Pre Menses; (M) = During Menses; (AM) = After Menses

Cramping \_\_\_\_ Stabbing \_\_\_\_ Burning \_\_\_\_ Bearing down sensation \_\_\_\_

Aching \_\_\_\_ Dull \_\_\_\_ Bloating \_\_\_\_ Consistent \_\_\_\_ Intermittent \_\_\_\_

### Please indicate if any apply to you and when you experience each symptom:

(N) = Never experience; (G) = Generally experience; (PM) = Pre Menses; (M) = During Menses

\_\_\_\_ Discharge \_\_\_\_ Vaginal Dryness \_\_\_\_ Headache \_\_\_\_ Dizziness \_\_\_\_ Mucus Issues \_\_\_\_ Bone issues

\_\_\_\_ Nausea \_\_\_\_ Swollen/Tender breasts \_\_\_\_ Water retention \_\_\_\_ Diarrhea \_\_\_\_ Constipation \_\_\_\_ Gas

\_\_\_\_ Anxiety \_\_\_\_ Mood swings \_\_\_\_ Depression \_\_\_\_ Poor appetite \_\_\_\_ Heavy appetite

\_\_\_\_ Dry skin \_\_\_\_ Acne/Skin eruptions \_\_\_\_ Rash/Itchy \_\_\_\_ Increased Libido \_\_\_\_ Decreased Libido

\_\_\_\_ Hot Flashes \_\_\_\_ Night Sweats \_\_\_\_ Insomnia \_\_\_\_ Hard to wake up \_\_\_\_ Fuzzy thinking/Lack of Focus

### Have you been diagnosed with?

Fibroids  Fibrocystic breasts  Endometriosis  Ovarian cysts  PCOS Other \_\_\_\_\_

### Please indicate your Birth Control History:

Medicine	Dosage	Reason	How long	Prescribed	Date of Last Checkup

## FOR MEN

Date of last prostate check-up \_\_\_\_\_ PSA results \_\_\_\_\_ Manual prostate exam results \_\_\_\_\_

Lab results \_\_\_\_\_

Frequency of urination: Daytime \_\_\_ Nighttime \_\_\_ Color of urine:  clear  murky  odor \_\_\_\_\_

Symptoms related to prostate:

- Prostate problems     Delayed stream     Dribbling     Incontinence     Retention of urine  
 Rectal dysfunction     Increased libido     Impotence     Premature ejaculation  
 Back pain     Decreased libido     Groin pain     Testicular pain  
 other \_\_\_\_\_

## SYMPTOM SURVEY (for everyone)

The following list of symptoms you may or may not experience.  
Please indicate as follows:

No mark ( ) = Never experience; Check Mark (✓) = Sometimes experience; Plus sign (+) = Frequently experience

- |   |  |   |   |
|---|--|---|---|
| <input type="checkbox"/> Lack of appetite   | <input type="checkbox"/> Abdominal pain                      | <input type="checkbox"/> Eye problems                       | <input type="checkbox"/> Fatigue                          |
| <input type="checkbox"/> Excessive appetite   | <input type="checkbox"/> Chest pain                          | <input type="checkbox"/> Jaundice                           | <input type="checkbox"/> Edema                            |
| <input type="checkbox"/> Loose stool or diarrhea                                      | <input type="checkbox"/> Sciatic pain                        | <input type="checkbox"/> Difficulty digesting<br>oily foods | <input type="checkbox"/> Blood in stool                   |
| <input type="checkbox"/> Digestive issues   | <input type="checkbox"/> Headaches                           | <input type="checkbox"/> Gall stones                        | <input type="checkbox"/> Black tarry stool                |
| <input type="checkbox"/> Indigestion  | <input type="checkbox"/> Pain or coldness<br>in genital area | <input type="checkbox"/> Light colored stool                | <input type="checkbox"/> Easily bruised                   |
| <input type="checkbox"/> Vomiting   | =====  | <input type="checkbox"/> Soft brittle nails                 | <input type="checkbox"/> Difficult to stop                |
| <input type="checkbox"/> Belching, burping  | <input type="checkbox"/> Cough                               | <input type="checkbox"/> Easily angered or<br>agitated      | <input type="checkbox"/> Asthma                           |
| <input type="checkbox"/> Heartburn/reflux   | <input type="checkbox"/> Shortness of breath                 | <input type="checkbox"/> Difficulty making<br>decisions     | <input type="checkbox"/> Tendency to get<br>colds easily  |
| <input type="checkbox"/> Feeling of retention of                                      | <input type="checkbox"/> Decreased sense of<br>smell         | <input type="checkbox"/> Spasms/twitching                   | <input type="checkbox"/> Intolerance to<br>weather change |
| <input type="checkbox"/> Tendency to become<br>obsessive in work,<br>relationships... | <input type="checkbox"/> Nasal problems                      | =====   | <input type="checkbox"/> Allergies                        |
| =====   | <input type="checkbox"/> Skin problems                       | <input type="checkbox"/> Low back pain                      | <input type="checkbox"/> Hay fever                        |
| <input type="checkbox"/> Insomnia/sleep difficulty                                    | <input type="checkbox"/> Feeling of<br>Claustrophobia        | <input type="checkbox"/> Hearing impairment                 | <input type="checkbox"/> Dizziness                        |
| <input type="checkbox"/> Heart palpitations   | <input type="checkbox"/> Bronchitis                          | <input type="checkbox"/> Knee problems                      | <input type="checkbox"/> Tendency to faint                |
| <input type="checkbox"/> Cold hands/feet  | <input type="checkbox"/> Colitis or diverticulitis           | <input type="checkbox"/> Ear ringing                        | <input type="checkbox"/> High cholesterol                 |
| <input type="checkbox"/> Nightmares   | <input type="checkbox"/> Constipation                        | <input type="checkbox"/> Kidney stones                      | <input type="checkbox"/> Sudden weight<br>loss            |
| <input type="checkbox"/> Angina pains   | <input type="checkbox"/> Hemorrhoids                         | <input type="checkbox"/> Decreased sex drive                |   |
|   | <input type="checkbox"/> Recent use of<br>Antibiotics        | <input type="checkbox"/> Hair loss                          |   |
|   |  | <input type="checkbox"/> Urinary problems                   |   |
| <input type="checkbox"/> Cold often?  | <input type="checkbox"/> Dislike the cold?                   | <input type="checkbox"/> Nighttime Sweats                   | <input type="checkbox"/> Dark urine                       |
| <input type="checkbox"/> Hot often?   | <input type="checkbox"/> Dislike the heat?                   | <input type="checkbox"/> Daytime Sweats                     | <input type="checkbox"/> Frequent Urination               |
|   |  | <input type="checkbox"/> Sweaty palms/feet                  | <input type="checkbox"/> Frequent thirst                  |
|   |  | <input type="checkbox"/> Like ice water                     |   |

## FERTILITY HISTORY

Please briefly describe your fertility history. You may include diagnosis for you and your partner, treatments, past and upcoming procedures with relative dates. Please add any other information you deem relevant.

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## DIET/LIFESTYLE HISTORY

Please indicate the use and frequency of the following:

	Yes	No	How Much?		Yes	No	How Much?
Coffee/ Black tea	<input type="checkbox"/>	<input type="checkbox"/>	_____	Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	_____
H2o Drugs	<input type="checkbox"/>	<input type="checkbox"/>	_____	Non-medical	<input type="checkbox"/>	<input type="checkbox"/>	_____
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	_____	Soda	<input type="checkbox"/>	<input type="checkbox"/>	_____
Microwave	<input type="checkbox"/>	<input type="checkbox"/>	_____	Aluminum/ Teflon Cookware	<input type="checkbox"/>	<input type="checkbox"/>	_____

Please indicate when you experienced any of the following past or present:

Allergies	Food sensitivities	Food cravings	Addictions
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**What role does exercise play in your life?**

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**Do you follow a regular awareness practice?**

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**What percentage of your food is home-cooked? \_\_\_\_\_ %**

**Where do you get the rest from?**

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**Please list foods you regularly eat:**

**As a CHILD...**

BREAKFAST

LUNCH

DINNER

SNACK/DESSERTS

LIQUIDS

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**As an Adult... (One year ago)**

BREAKFAST

LUNCH

DINNER

SNACK/DESSERTS

LIQUIDS

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**As an Adult... (Presently)**

BREAKFAST

LUNCH

DINNER

SNACK/DESSERTS

LIQUIDS

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# THE BERKLEY CENTER for Reproductive Wellness

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

Is your diet mostly cooked, raw or combination? \_\_\_\_\_

Please indicate which of the following you eat and the frequency:

(O)= Often; (S)= Sometimes.

- |                                     |   |   |
|-------------------------------------|---|---|
| <input type="checkbox"/> Red Meat   | <input type="checkbox"/> Cow Milk             | <input type="checkbox"/> Ice Cream              |
| <input type="checkbox"/> White Meat | <input type="checkbox"/> Goat Milk            | <input type="checkbox"/> Yogurt                 |
| <input type="checkbox"/> Pork       | <input type="checkbox"/> Cheese               | <input type="checkbox"/> Pastries/Cookies/Candy |
| <input type="checkbox"/> Eggs       | <input type="checkbox"/> Butter               | <input type="checkbox"/> Fried Food             |
| <input type="checkbox"/> Fish       | <input type="checkbox"/> Margarine/Shortening |   |

- |                                      |                                      |                                     |                                    |   |
|--------------------------------------|--------------------------------------|-------------------------------------|------------------------------------|---|
| <input type="checkbox"/> Beans       | <input type="checkbox"/> White Rice  | <input type="checkbox"/> Brown Rice | <input type="checkbox"/> Quinoa    | <input type="checkbox"/> Seeds            |
| <input type="checkbox"/> Tofu/Tempeh | <input type="checkbox"/> White Bread | <input type="checkbox"/> Amaranth   | <input type="checkbox"/> Oats      | <input type="checkbox"/> Nuts/Nut Butters |
| <input type="checkbox"/> Miso        | <input type="checkbox"/> Pasta       | <input type="checkbox"/> Millet     | <input type="checkbox"/> Buckwheat |   |

Indicate your preference in taste:

(+)= Like; (-)= Dislike.

- |                                  |                                |
|----------------------------------|--------------------------------|
| <input type="checkbox"/> Spicy   | <input type="checkbox"/> Salty |
| <input type="checkbox"/> Bitter  | <input type="checkbox"/> Sweet |
| <input type="checkbox"/> Pungent | <input type="checkbox"/> Sour  |

Please list the veggies you eat:

Please list the fruit that you eat:

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FOR OFFICE USE ONLY

## CANCELLATION & RESCHEDULING POLICY

We understand that there are times when you will need to cancel and/or reschedule your appointment. We are pleased to accommodate your needs.

It is our policy, however, that all cancellations and/or rescheduling must be done at least **24 hours** prior to the date of your appointment.

A fee of \$50.00 will be charged if your cancellation/re-scheduling is not done two business days prior to the date of your appointment.

Thank you for your understanding.

Please sign here indicating that you understand and accept this policy:

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*Patient Signature*

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Date

## LEGAL WAIVER

I am attending this nutritional consultation and working with Kathie Alli, CHHC of my own volition. Kathie Alli recommends that you inform your medical doctor of any and all dietary changes which you make as a result of Kathie Alli's recommendations.

I understand that Kathie Alli, the person leading and teaching this program, is not a doctor or registered dietician. I take full responsibility for my health and for the decisions regarding my diet that I make as a result of Kathie Alli's recommendations.

I understand that Kathie Alli is a Certified Holistic Health Counselor, trained to help guide clients regarding the improvement of their health through dietary and lifestyle changes. She is not an herbalist or legal administrator of specialized supplements. Any dietary supplements that are recommended are suggestions and whether or not I partake of these suggestions is as a result of my own volition.

I hereby release and discharge Kathie Alli from any and all claims that I or anyone in association with me, have or may have, now or in the future. I have read and understand all of the above, and agree to proceed under these conditions.

I understand that the above is meant to have legal significance and be legally binding.

\_\_\_\_\_  
Print your full name

\_\_\_\_\_  
Sign your full name

\_\_\_\_\_  
Today's date

**ADVICE TO CONSULT A PHYSICIAN**

We, the undersigned, do affirm that \_\_\_\_\_ has been advised by Kathie Alli, Certified Holistic Health & Nutrition Counselor to consult a physician regarding the condition or conditions for which such patient seeks Nutritional Counseling.

I, \_\_\_\_\_ have received a copy of this document.  
*Please print your name*

\_\_\_\_\_  
*Patient Signature*

\_\_\_\_\_  
Kathie Alli, HHC, AADP

\_\_\_\_\_  
Date