

Change Your Diet... Change Your Life!

I would like to welcome you to the nutritional services offered by Marina Zelenovic of Everything Zen Nutritional Consulting. As a health care professional, it is my goal to provide you with the most caring and efficient treatment possible. In an effort to do just that, here are a few guidelines.

Appointments: To serve you best, I strive to run my practice "on schedule". Occasionally however, an emergency may occur to disrupt this schedule, and I apologize in advance should that happen and delay your visit in any way. Your prompt arrival for scheduled appointments, coupled with forms that are filled out in advance, will keep this running smoothly.

What to Expect During Treatment: Initial appointments last approximately 1 hour and 15 minutes. To this appointment you are required to bring this completed form (if you have not had time to do so in advance, please try to arrive 20-30 minutes prior to your session so you may fill out at least the first 3-5 pages, as this will expedite the consultation).

We will first carefully go through your completed assessment form, at which time you are free to voice any health concerns you most want to be addressed. We will discuss your lifestyle and dietary habits in great detail.

Upon completion of the assessment, recommendations will be made so that you can immediately begin to enhance your own health and well-being. At this time, in order to better determine interior bodily terrain, you will be asked to do some 'homework' by keeping track of your: eating habits, temperature and urine & saliva pH by filling out the requisite charts. These charts should be faxed back BEFORE your follow up appointment. Additional literature will also be given, to both explain procedures, as well as provide you with more detailed information on various aspects of health to assist you in making lasting lifestyle and dietary changes.

Two to four weeks later you will likely be required to return for a follow up appointment in which we will discuss some of the changes you have incorporated and obstacles you have encountered; a more detailed program will be given that is specific to your symptoms, lifestyle and dietary habits. At this time, further testing may be recommended, such as: Live Blood Analysis, Vitamin C / Antioxidant Level Test, Calcium Uptake & Digestive Sufficiency Test, Oxidata (Free Radical Activity) Test, Adrenal Sufficiency or Hair Mineral Analysis ~ to further explore any internal imbalances/deficiencies.

Depending on the individual, and program, follow-ups will range from once or twice a month, to once every 3-4 months at which time we will reexamine your situation and make even more changes to your protocol as your health improves!

I look forward to addressing your health concerns, and assisting you in your journey towards improved health and well-being. Please do not hesitate to let me know if you have any questions or comments concerning your care.

Cancellations: I understand that circumstances arise that may prevent you from keeping your appointment. I do require 24 hours notice for cancellations, otherwise a fee of 50% of the visit will be charged to you for the unused time slot if less than 24 hours is given

Payment Policies: Payment is due at the time service is rendered unless other arrangements have been made in advance.

Sincerely,

Marina Zelenovic

Nutrition Assessment Form

Name : _____ Age: ____ Phone: () _____ Occupation _____

Address _____

Email: _____ Do you want to get our newsletter? Y N

Height _____ Weight _____ Blood Type: A AB B O

Referred By: ___ Doctor ___ Friend ___ Relative ___ Brochure ___ Other ___

Have you been diagnosed with any illness/condition? (please list) i.e. arthritis, high blood pressure

Please list your main health complaints, in order of importance

	Complaint	Since	Causes
1.			
2.			
3.			

Do you take any regular medications? Please list _____

Do you take any regular vitamin, mineral or herbal supplements? Please list _____

Mark a check (√) on any problem you have had occasionally in recent history; mark 2 checks (√√) if the problem occurs often; and 3 checks (√√√) if the problem is frequent and severe.

Metabolism

Have you recently lost/gained weight? Y N

Do you gain/lose weight easily? Y N

Skin (please check 1-3)

Do you have/had: Eczema ___ Psoriasis ___

Dry Skin ___ Itching ___ Rashes ___

Acne ___ Warts ___ Hair loss ___

Bruise easily ___ Athletes Foot ___

Immunity (please check 1-3) Are you prone to:

Colds ___ Flues ___ Fevers ___

Chills ___ Cold or sweaty hands/feet ___

Sore throats ___ Runny/stuffed nose ___

Sinus infections ___ Ear infections ___

Yeast infections ___ Other infections ___

Allergies ___ Mucous problems ___

Hay fever ___ Swollen glands ___

Muscular/Skeletal Do you experience (1-3):

Muscle: Tension ___ Cramping ___ Pain ___

Bone/joint Problems ___ Arm/Leg problems ___

Do muscle pains move to diff. parts of the body ___

Joint swelling (where) ___ Back Problems ___

Pain in lower back, after prolonged sitting ___

Involuntary movement ___ Sprain easily ___

Any: broken bones _____

torn ligaments _____

Energy

Rate your energy levels (0 = low, 10 = high)

Does your energy fluctuate throughout the day Y N

What time of day are you least energetic _____

Have your energy levels recently changed? _____

Do you: fatigue easily? Have poor endurance?

Do you often get: (please check 1-3)

Headaches ___ Migraines ___ Neck pains ___

Shoulder tension ___ Ringing in the ears ___

Dizziness ___ Sinus pressure ___ Nosebleeds ___

Blurry vision ___ Eyestrain ___ Earaches ___

As a CHILD did you often :

Catch: colds ___ Flues ___ Have: tonsilitis ___

Allergies ___ Ear Infections ___ Other infections ___

Were you often on anti-biotics _____

Did you have any surgeries _____

How healthy were you as a child (1-10)? ___

Urinary (please check 1-3)

Are you prone to: Bladder infections ___

Blood in the urine ___ Urine Lost its force ___

Burning on urination ___ Prostate problems ___

Pain in the bladder area ___

How many times do you pee: during day ___

During the night? ___

Do you ever get (please check 1-3):

Difficulty breathing ____ Shortness of breath ____ Wheezing ____ Coughing ____
Heart palpitations ____ Chest pain ____ Itching (Nose) ____ Rectal Itching ____
Coughing up blood ____ Breast lumps ____ Night sweats ____ Seizures ____

What are your cholesterol levels? _____ Triglyceride levels? _____ Blood Pressure? _____
Are you anemic? _____

Emotions

(0 = never/rare, 1 = occasional, 2 = sometimes, 3 = often, 4 = unbearable)

Are you now, or have you been depressed? Y N Ever taken anti-depressants? (please list) _____

Are you happy right now? (1-10, 10 being highest) _____ What are your biggest fears? _____

How Often do you:

Feel anxious, nervous or tense ____ Feel Sad ____ Stressed Out ____ Become Overwhelmed ____

Get irritable ____ Lose your temper ____ Put others' needs ahead of your own? ____

Indulge in your favorite activities? Never Rare (<1x month) 1x week 2-3x week Most days

Digestion

Do you ever get: or suffer from (please check 1-3):

Bloating ____ Gas ____ Nausea ____ Heaviness after meals ____ Abdominal pain ____

Burning in the stomach ____ Loss of taste for meat ____ Gas/Bloating from most foods ____

Do any foods in particular bother you? _____

Do these foods upset you: Raw Cabbage Coleslaw Onions Green Peppers
Cucumbers Radishes Rich Foods Greasy Foods Spicy Foods

Do you experience digestive difficulties? Y N Describe _____

Elimination

How many bowel movements do you have per day? _____ Do you feel you eliminate completely? _____

Stool appearance (please circle all that apply): Formed Unformed Long Short Pellets Mucousy
Yellow Brown Black Bloody Float Sink Runny

Are you ever: Constipated ____ Diarrhea ____ Alternating diarrhea & constipation ____

Have you ever suffered from: hemorrhoids ____ anal fissures ____

Has any of this changed in the past 12 months? _____

General

How would you rate your overall health? Poor ____ Ok ____ Good ____ Excellent ____

What illness are you most afraid of getting? _____

What do you most want to get out of this nutritional evaluation? _____

Women

Date of last menstrual period _____ Are your periods regular? Y N Length of cycle ____

Absent periods? Y N Bleeding between periods? Y N Painful/symptomatic periods? Y N

Blood: bright red dark clotted (circle one) other _____

Vaginal discharge? Thick non-clear odorous burning (circle) other _____

Do you suffer from PMS? (please circle) Bloating/Edema Cramps Increased Appetite Insomnia Moodiness

Number of pregnancies? _____ deliveries _____ abortions _____ miscarriages _____

What type of birth control do you, and did you, practice?

Are you now on, or have you ever taken birth control pills? ____ For how long? ____ Began when? ____

Are you still on the pill? Y[] N[] Are you now or have you ever been on estrogen replacement therapy? ____

Health History

Have you been vaccinated? Y[] N[] Do you get the flu shot? Y[] N[]

Are you allergic to: any medications? Please list _____

Foods? _____

Environmental toxins? _____

What drugs have you taken in the past? (Include prescription, over-the-counter, antibiotics, and recreational)

Have you had any operations? _____

Any major accidents or injuries? When and what? _____

Do you have: bad breath ____ Teeth/gum problems ____ Sores around the mouth ____

• Teeth glassy on the ends? Rough on the edges? Gums Receding ____

• Tongue: Coated ____ Dry ____ Hot ____

• Silver dental fillings? ____ How many? ____ Have you had any removed? ____

How many? ____ When? ____ By whom? ____ Why? _____

• Root canals? ____ How many? ____

• Crowns or other metals (braces, "flippers", partials, retainers etc.) in the mouth? _____

Describe _____

Describe your symptoms and health history as completely as possible: _____

Describe what diseases are predominant on both sides of your family

Maternal _____

Paternal _____

Lifestyle

Do you smoke? ____ Have you ever? ____ How many cigarettes per day ____ For how long? ____

If you quit, when? ____ Does anyone in your house smoke? ____ Your workplace? ____

How often do you have an alcoholic beverage? ____ Have you ever been treated for alcoholism? ____

How many hours a day do you work? ____ Do you enjoy your work? ____

Do you like your coworkers? ____ Your boss ____

How many hours a day do you sleep? ____ Do you awaken feeling rested? _____

Suffer from insomnia? ____ Do you have difficulty falling or staying asleep? _____

How often do you: Exercise? _____ What do you do? _____
Meditate _____ Stretch _____ Have a treatment? Get a massage _____ Accupuncture ____
Chiro _____ Physio _____ Reflexology _____ Other _____

How many hours a day do you: watch television? _____ Read? _____ Spend in front of the computer? _____

Do you vacation regularly? _____ When was your last vacation? _____

What level of stress are you experiencing right now? Minimal ____ Average ____ Considerable __ Unbearable ____

Has there been any remodeling/construction in your home recently (sheet rock, paint, new carpets)?

Do you use a microwave oven? _____ Electric blanket? _____ Cellular phone? _____

Do you live near any farms or large agricultural projects? If so, what kind (dairy, vegetable, orchard etc)

What kind of lighting is used at: Home _____ Work _____

Please describe your typical daily routine (from start to finish) _____

Please list any other information you feel may be relevant

Anabolic/Catabolic

- Y N Do you have to get up at night to urinate? (the need to urinate is awakening you, not just urinating because you are already up) How many times per night? _____
Y N Do you tend towards constipation?
Y N Do you tend toward polyuria? (overly frequent urination, with volume)?
Y N Do you tend toward somnolence (difficulty awakening in the morning)?

Count your YES answers and your NO answers in this section; write the numbers here

Total YES _____ Total NO _____ Yes > No = Anabolic

- Y N Do you feel you are a "morning person"?
Y N Do you tend toward oliguria (insufficient urination, perhaps often but small amounts)
Y N Do you tend toward diarrhea?
Y N Do you tend toward insomnia (difficulty falling asleep or staying asleep)?
Y N Do you get up easily in the morning but find yourself tired in 2+ hours?

Count your YES answers and your NO answers in this section; write the numbers here

Total YES _____ Total NO _____ Yes > No = Catabolic

Have you noticed?

Please indicate CURRENT conditions and the severity:

Blank = never 1 = rarely 2 = occasionally 3 = sometimes 4 = often 5 = constant

Section 1:

Poor Co-ordination Low Hormone Levels Pre-Mature Aging
 Muscle Wasting Fluid Retention in the hands or feet Dry, lifeless hair

Section 2:

Fatigue/Lethargic Acne Age Spots
 Cellulite Dry/Coarse Hair Gray Hair
 Feel Cold Often Frequent Constipation Low Sex Drive
 Introversion Depression Mental Dullness
 Lack of Perspiration Hypoglycemia Low Blood Pressure
 High Cholesterol High Triglycerides Weight gain

Section 3:

Energetic Flush Easily Ruddy Complexion
 Hair loss at young age Frequent Bowel Movements Strong Sex Drive
 High Strung, Nervous Warm All The Time High Blood Pressure
 Quick thinker, Mentally Alert Outgoing, High Self Esteem Rapid Pulse

Section 4:

Goose Bump Easily Startle Easily Perfectionist
 Prefer Being Alone Eyes Sensitive to Bright Light Crave Salt
 Lump in Throat When Upset Lose Voice When Upset Anxiety
 Chronic Fever, Low Grade

Section 5:

Poor Response to Exercise Morning Stiffness & Nausea Motion Sickness

Section 6:

Motion Sickness Hypoglycemia Diabetes
 Crave sugar or coffee Feel Shaky When Hungry Irritable before Meals

Section 7:

Overweight ~ Recent Quick gain For many years Other: _____
 Fingernails... Split Brittle Rough Soft Ridges White spots?
 Forgetful (long-term memory) Absent-minded (short-term memory)
 Numbness of hands or feet Which?
 Sluggish in the morning
 Allergies: Eczema Asthma Hayfever
 Eyes bulging/protruding... Both? Right? Left?
 Dimness of vision Have cataracts? Which eye? Both?
 Poor appetite Always hungry
 Male: prostate trouble Male: lump(s) in testicle Male: difficult urination
 Female: painful periods Female: menstrual cramps Female: clots in flow
 Female: backache with period Female: hot flashes

Diet

Crave: salt _____ Sugar _____ Carbs _____ Junk food _____

Do you drink coffee? Y[] N[] How many? _____ Black tea? Y[] N[] How many? _____

How many times do you eat the following foods? (either per day = d; or per week = w)

Fruits d=_____ w=_____ What Kind: _____

Vegetables d=_____ w=_____ What Kind: _____

Salads d=_____ w=_____ How do you dress your salad?: _____

Cereal d=_____ w=_____ What kind? _____

Bread d=_____ w=_____ White Whole Wheat Multi Grain Bagels Other _____

Pasta d=_____ w=_____ White Whole Wheat Spelt Rice Corn Other _____

Rice d=_____ w=_____ What kind? White Instant Brown Wild

Potatoes d=_____ w=_____ How prepared? Mashed Baked Roasted Boiled French Fries

Red Meats d=_____ w=_____ Chicken d=_____ w=_____ Fish d=_____ w=_____

Milk d=_____ w=_____ Cheese d=_____ w=_____ Yogurt d=_____ w=_____

Soy milk d=_____ w=_____ Tofu d=_____ w=_____ Tempeh d=_____ w=_____

Meat substitute (soy) d=_____ w=_____ Nuts and seeds d=_____ w=_____ Beans/lentils d=_____ w=_____

Frozen dinners d=_____ w=_____ Such as? _____

Pre-made food=_____ w=_____ Such as? _____

Canned food d=_____ w=_____ Tuna/Salmon/Sardines Soups Veggies Fruit Beans Sauces

C hocolate d=_____ w=_____ Bars Pure Chocolate Milk Chocolate Dark Chocolate
Chocolate Flavored sweets (cookies, brownies, ice cream, cakes)

Candy d=_____ w=_____ Such as? _____

Gum d=_____ w=_____ Sugar free Regular

Ice Cream d=_____ w=_____ Regular Light Fat Free Gelato

Protein Shakes d=_____ w=_____ What type of Protein? Whey Soy Rice Egg

Protein bars d=_____ w=_____ Which ones? _____

Muffins/donuts d=_____ w=_____ Cookies d=_____ w=_____

Desserts d=_____ w=_____ Such as? _____

Chips d=_____ w=_____ Regular Baked Healthy Alternatives (Terra)

French Fries d=_____ w=_____ Such as? _____

Take out d=_____ w=_____ Such as? _____

Fast Food d=_____ w=_____ Such as? _____

Margarine d=_____ w=_____

Cold Cuts d=_____ w=_____

What percent of your diet is: raw _____ cooked _____

What percentage of your protein intake comes from: Beef _____ Pork _____ Chicken _____ Turkey _____
Fish _____ Eggs _____ Soy Products _____ Protein Supplements _____ Other _____

List frequently used spices _____

What percentage of your foods are: **Home Prepared** **Restaurant** **Take Out**

What cooking methods do you use? (circle) **BBQ Bake Broil Cook Fry Grill Microwave Raw**
Steam Stir Fry Sautee Poach Boil

What fats/oils do you use? _____

How many cups/bottles/glasses do you drink on average, per day (and/or per week)?

Coffee _____ Black tea _____ Herbal tea _____ Milk _____ Fruit Juice _____
Vegetable Juice _____ Soft drinks _____ Diet Soda _____ Water _____ (tap purified bottled)
Perrier _____ Beer _____ Wine _____ Liquor _____

What 3 foods do you crave the most/ eat the most (if you could eat anything, healthy or not, what would it be)

1. _____ 2. _____ 3. _____

Write a typical 5 day diary. Please include snacks and timing of meals.

Breakfast:

Time:

Appetite: 0 (None) – 5 (Starving): _____

1)

2)

3)

4)

5)

Time _____ Snacks:

Lunch:

Time:

Appetite: 0 (None) – 5 (Starving): _____

1)

2)

3)

4)

5)

Time _____ Snacks:

Dinner

Time

Appetite: 0 (None) – 5 (Starving): _____

1)

2)

3)

4)

5)

Time _____ Snacks:

Do your meals (and times) change during the weekend? If so how?

Breakfast: Skip it Eat it (normally don't) Eat Larger Breakfast, such as: _____

Lunch: Skip it Eat later Eat Larger Lunch, such as: _____

Dinner: Skip it Eat later Eat out Eat larger dinner, such as: _____

Other: _____

How long have you been eating this way? _____

Have you tried various weight loss diets, if so please list which ones and your 'dieting' behaviour: _____

What is the best part of your diet? _____

What is the worst part of your diet? _____

What do you want the most help with, with regards to your diet? _____

Are you willing to make changes?

Please share your preferences and tendencies by circling &/or entering details:

Section 1A ~ On the average...

Y N Appetite is strong at: Breakfast Lunch Dinner

Y N Meat or fish makes me more energetic for: Breakfast Lunch Dinner

Y N Eating before bed improves my sleep **Section 1B**

Y N Fruits generally do not agree with me Y N Fruits generally agree with me

Y N I crave salt Y N OJ in the AM agrees with me

Y N I love to eat, not to subsist Y N I crave sweet desserts

Y N Often I get hungry between meals Y N Vegetarian meals satisfy me

Y N Fasting makes me feel bad

Y N A meal heavy with fats agrees with me

Y N Going without food for 4 hours is uncomfortable

Y N I feel bloated after I eat

Y N I perspire a lot

Y N I am frequently warm

Count your YES answers and your NO answers in this section; write the numbers here

IA Total YES _____ Total NO _____ Yes>No = Diet 1

IB Total YES _____ Total NO _____ No>Yes = Diet 2

