Grey Matters Neurofeedback & Counseling
Shari Johansson, MA, LPC, NCC, BCN, QEEG-D
12211 W. Alameda Pkwy., Ste. # 110
Lakewood, CO 80228 720-726-6597

One's health and well-being are influenced by many different things, including lifestyle, family history, emotional health, and nutrition/eating habits. Please complete the following questionnaire to the best of your ability to give us an overall view of your general lifestyle and health habits.

New Patient Nutrition Assessment Form

First Name _____Middle Name_____Last Name_____

Address _____ City _____State_____Zip:_____

Please indicate your preferred method of contact: home work cell email

Home Phone (_____)_____-_____ Birth Date _____/_____/_____ Age _____

Work Phone (_____)_____-_____ Email address: _____

Cell Phone (_____)_____-_____

Occupation _____ Marital Status _____

Do you have children? Yes No Age of children_____

Primary Care Provider _____ Date of last physical exam _____

Other doctors or practitioners you see _____

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GOALS AND READINESS ASSESSMENT

My overall, health goals are…

_____
_____
_____

In the past, I have tried the following techniques, behaviors, etc. to reach my health goals…

_____
_____
_____

On a scale of 1 (not willing) to 5 (very willing), please indicate your readiness/willingness to do the following:

To improve your health, how ready/willing are you to…	**1**	**2**	**3**	**4**	**5**
Significantly modify your diet					
Take nutritional supplements each day					
Modify your lifestyle (ex: work demands, sleep habits, physical activity)					
Practice relaxation techniques					
Engage in regular exercise/physical activity					

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PAST MEDICAL AND SURGICAL HISTORY

Please indicate whether you or your relatives* have been diagnosed with any of the following diseases or symptoms (specify which relative and the date of diagnosis). *Relatives include: parents, grandparents, siblings.

Illness/Disease/Symptom	Self: Age Diagnosed	Relative: Age Diagnosed	Describe/Specify
Allergies (please specify type of allergy)			
Anemia			
Anxiety or Panic Attacks			
Autoimmune condition (specify type)			
Cancer			
Chronic Fatigue Syndrome			
Crohn's Disease or Ulcerative Colitis			
Depression			
Diabetes (Specify: Type I, II, Prediabetes, Gestational Diabetes)			
Eczema			
Epilepsy, convulsions, or seizures			
Fibromyalgia			
Food Allergies or Sensitivities			
Heartburn			
Heart disease (specify)			
Hepatitis			
High blood pressure (hypertension)			
Hypoglycemia (low blood sugar)			
Intestinal Disease (specify)			
Irritable bowel syndrome			
Liver disease			
Mononucleosis			
PMS			
Polycystic Ovarian Syndrome			

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Illness/Disease/Symptom	Self: Age Diagnosed	Relative: Age Diagnosed	Describe/Specify
Psychiatric Conditions			
Sleep apnea			
Stroke			
Thyroid disease (hypo- or hyperthyroid)			
Injuries	**Age**	**Describe/Specify**	
Head injury			
Neck injury			
Other (describe)			
Diagnostic Studies	**Age at study**	**Describe/Specify**	
CT			
MRI			
EEG			

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MEDICATION, SUPPLEMENT, AND ANTIBIOTIC INTAKE: Please provide the names of medications, supplements, and/or antibiotics that you are currently taking:

Medication/Supplement/ Antibiotic	Dose	Units	Frequency	Start Date	Stop Date
Example: One-a-Day (brand) Men's Multivitamin	1200	Mg	Daily	08/12/2007	current

Are you allergic to any medications? Yes No Please list: _____

Please indicate how often you have taken antibiotics during each life stage:

	< 5 times	> 5 times
Infancy/ Childhood		
Teen		
Adulthood		

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LIFESTYLE

Physical Activity: Using the table, please describe your physical activity.

	Type/Intensity (low-moderate-high)	# Days per week	Duration (minutes)
Physical Activity			

_____

Indicate daily stressors and rate the level of stress from 1 (extremely low) to 10 (extremely high):

Work_____ Family_____ Social_____ Financial_____ Health_____ Other_____

What helps you to unwind?_____

On average, how many hours of sleep do you get? Weekdays_____ Weekends_____

Do you smoke? ☐ Never ☐ In the past ☐ Currently How long?_____

Alcohol use ☐ Never ☐ In the past ☐ Currently Type/amount/frequency_____

Drug use ☐ Never ☐ In the past ☐ Currently ☐ Prefer not to discuss Type/Frequency _____

DIGESTIVE HISTORY

- Do you associate any digestive symptoms with eating certain foods? ☐ Yes ☐ No
- Please explain:_____
  _____