Nature's Pharmaceuticals, Inc.
18230 F.M. 1488; Ste: 100
Magnolia, Texas 77354
(281) 356-9089 – Phone
(281) 356-9659- Fax
frede@magnoliapharmacy.com – Email
www.foodmd.com - Website

PATIENT/CLIENT INTERVIEW FORM

Name		**Date**			
Address		**D.O.B./AGE**			
City		**State**		**Zip Code**	
Home Phone		**Work Phone**			
Cell Number		**Email Address**			
Fax Number		**Wakeup Time**		**Bedtime**	
Height		**Weight**		**BMI**	**Blood Type**

Personal Medical History*

X	Medical Condition	Family History
	Heart Attack – AMI	
	Bypass Surgery - CABG	
	Angioplasty	
	Thrombolytic Treatment	
	Angiography	
	Stress Test/Echocardiogram	
	High Cholesterol	
	High Triglycerides	
	High blood pressure	
	Diabetes	
	Hypoglycemia	
	Excessive weight gain	
	Vision disturbances	
	Kidney Disease	
	Liver Disease	
	Acanthosis Nigricans	
	Polycystic Ovarian Syndrome	
	Glucose Intolerance	
	Abnormal Lab Tests	
	Other (Surgeries, etc.)	

*Provide explanations:

Dietary History – Note Year

X	Program	Year
	Atkins Diet Plan	
	Jenny Craig	
	Protein Power	
	Weight Watcher	
	Other:	

Past or current medications

X	Medications	Date
	Dexedrine	
	Fastin/phentermine	
	Meridia	
	Metobolife	
	Xenical/Orlistat	
	Phen-Fen	
	Redux	
	Herbals	
	Medications/Nutritional Supplements (list below)	

Carbohydrate Sensitivity Survey

Please circle either "T" for True or "F" for False. – select the answer that most closely matches your current food habits.

T	**F**	**I drink at least one sugared or caffeinated drink each day.**
T	**F**	**I have cravings for sugar, coffee or chocolate daily. (Please circle which one(s) apply.)**
T	**F**	**I hide candy or sweets in my home, car or office to eat at a later time OR openly eat these foods often.**
T	**F**	**I have soda, bread and grain products (crackers, chips, etc.), or sweets (cookies, cake, pie, candy, etc.) with most meals.**
T	**F**	**I can not stop eating after several pieces of candy or other sweet food.**
T	**F**	**I often drink caffeinated drinks in the morning with cereal, toast, bagel, tortillas, donuts or sweet rolls.**
T	**F**	**I have mood or energy "swings" throughout the day.**
T	**F**	**I experience the "shakes," irritability, fatigue, drowsiness or cravings within 2 hours of a meal high in sugar or high starch OR if I skip a meal.**
T	**F**	**I feel sleepy after eating large meals, a typical holiday meal or a pasta meal.**
T	**F**	**I get headaches (sometimes with dizziness and nausea) after meals with sweets, grain**

If you answered True to at least two of the above questions, you have a mild degree of carbohydrate sensitivity. If you answered True to more than three questions, you have a high degree of carbohydrate

AGE	WEIGHT
Pre-puberty	
Teenager	
Adult (20- 25)	
Adult (26 - 35)	
Adult (36 – 45)	

Please describe of Typical Meal. List your food types eaten and meal type and content.

Breakfast	
Midmorning Snack	
Lunch	
Afternoon Snack	
Dinner	
Bedtime Snack	
Food Allergies	

Lifestyle Survey

Survey Question	Response
Do you smoke or use nicotine products?	
If YES – how much and what type.	
Do you drink alcohol?	
If YES – how much and often.	
Do you use recreational drugs?	
If YES – what type and how often	
Do you exercise?	
If YES – what type and how often	
Do you use artificial sweetneners?	
If YES – what type and how often	
Do you consume caffeine products?	
If YES – what type and how often.	
How much sleep do you get each night?	
Do you have trouble falling or staying asleep?	
Have you ever been diagnosed with an eating disorder?	
Do you crave sweets or starches?	
Do you drink regular soft drinks.	
Do you drink diet soft drinks.	
Are you constipated?	
Do you like the taste of water?	
Are you motivated to make lifestyle changes?	