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Eating For Energy

Name: _____ Telephone: _____

Age: _____ Height: _____ Weight: _____

The three foundational components of good health are:

1. Structural
2. Psychological
3. Chemical (nutritional)

Please fill out this form before your nutritional consultation with Dr. Schillinger.

The four basic principles that will be covered include:

1. How to eat.
2. What to eat.
3. Supplements for specific symptoms.
4. A total wellness program.

Check any of the following that apply to you

- I
- Indigestion/gas/bloating after eating
 - Drink liquids with meals
 - Sleepy or hungry after eating
 - Use antacids for heartburn

- III
- Overweight
 - Craving certain foods
 - Binge eating
 - Water retention

- V
- Restless, agitated, or angry
 - Slowly gaining weight
 - Low energy
 - Hot flashes (women only)

- II
- Frequently feel fatigued
 - Wake un-refreshed in the morning
 - Frequent headaches throughout day

- IV
- Achy joints
 - Muscle stiffness
 - Muscle spasms
 - Numbness/weakness in arms/legs

Use this frequency guide regarding the following food groups.

Frequently = a few times per week **Occasionally** = a few times per month **Rarely** = a few times per year

Daily frequently occasionally rarely never

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—	—	—	—	—	White Bread Products	—	—	—	—	—	Nuts and Seeds
—	—	—	—	—	White Rice / Pasta	—	—	—	—	—	Legumes and Beans
—	—	—	—	—	White Sugar Products	—	—	—	—	—	Fresh Vegetables
—	—	—	—	—	Packaged Foods	—	—	—	—	—	Fresh Fruit
—	—	—	—	—	Deep Fried Foods	—	—	—	—	—	Whole Grains
—	—	—	—	—	Fast Food	—	—	—	—	—	Organic Food
—	—	—	—	—	Cheese / Cheese Products	—	—	—	—	—	Raw Food
—	—	—	—	—	Milk / Milk Products	—	—	—	—	—	Sprouted Food
—	—	—	—	—	Eggs	—	—	—	—	—	Fruit Juice
—	—	—	—	—	Red Meat / Cold Cuts	—	—	—	—	—	Vegetable Juice
—	—	—	—	—	Soda	—	—	—	—	—	Water __oz. / day
—	—	—	—	—	Coffee __cups / day	—	—	—	—	—	Salt / salted foods
—	—	—	—	—	Alcohol	—	—	—	—	—	chocolate
—	—	—	—	—	Pain Medication	—	—	—	—	—	oil
—	—	—	—	—	Cigarettes __ packs / day	—	—	—	—	—	butter

List any **supplements** you are currently taking and for what purpose.

Indicate any **health goals** you may have.

_ **Lose weight** approx. # of lbs. _____ _ **Gain weight** approx. # of lbs _____
 _ **Exercise** more frequently _____ minutes _____ times per week _ Increase **energy**
 _ Other: _____

Frequency of **eating** food each day: _____

Amount of **water** consumed per day: _____

Number of **bowel movements** per day: _____

I prefer a morning / afternoon appointment (circle one).

Take your health to the next level!