Systems Survey Packet

Name: _____

Date: _____

Email: _____

Forms Included:

- Systems Survey (for client)
- History of medications and surgeries (for client)
- Current list of supplements (for client)
- Womens Cycle and Birth Control History (for female clients only)
- Symptom Tracking Sheet (to be filled out by practitioner)

Please read all instructions carefully before filling out attached paperwork:

1) Systems Survey:
   Only fill out symptoms that apply to you and rank as 1, 2 or 3 in severity. All symptoms that DO NOT apply to you please cross out. ***At the end do not forget to list your five main complaints in order of importance.
2) History of Medications and Surgeries:
   List any and all PAST and PRESENT medications: name, dose, duration of use and year stopped and started. Surgeries: name and year
3) Current List of Supplements:
   What supplements have you take in the past, and what are you currently taking - Name of supplement company, dose, duration of use, year started and stopped.
4) Women's Cycle and Birth Control History:
   History of Birth Control - name of birth control, year started and stopped. Cycle history: # of days, blood flow volume, blood flow color change, symptoms before menses, painful ovulation… any other significant symptoms past and present.

Practitioner Use Only:

5) Symptom Tracking Sheet:
   For all of the symptoms on the Symptom Survey that were marked as a 3, list on the Tracking Sheet and fill out all of the additional information. You may need to consult with the client during this time for exact information.

End of Systems Survey:

_____☐_____ Client received SP Food Journal to fill out for follow up appointment.

_____☐_____ Client received additional handouts to take home and return 48 hours before next visit.

_____☐_____ Date Report of Findings is scheduled for.

Summary of Nutrition Profile and Commitment to Care. The client….

History of Medications and Surgeries

Name: _____

Date: _____

Please list any and all past and present:

Medications

Name	Dose	Duration of Use	Year Started	Year Stopped

On a scale 1-10 how committed are you to getting off of your current medications?
1 not likely, 10 very likely. _____

Surgeries

Surgery/Procedure	Year

Notes:

Current List of Supplements

Name: _____

Date: _____

What supplements have you take in the past, and what are you currently taking? Please provide name of supplement company, dose, duration of use, year started and stopped.

Supplements

Name	Company	Dose	Duration of Use	Year Started	Year Stopped

Notes:

Womens Cycle and Birth Control History

Name: _____

Date: _____

Please provide past and present:

- Birth Control - name of birth control, year started and stopped
- Menses history - number of days, blood flow volume, blood flow color change, symptoms before menses, painful ovulation and any other significant symptoms

Birth Control

Name	Dose	Duration of Use	Year Started	Year Stopped

Monthly Cycle

Number of Days: _____

Blood flow volume (please select): HEAVY ◯ MEDIUM ◯ LIGHT ◯

Please describe flow and color change during cycle:

_____

Please describe ymptoms before and during menses:

_____

Painful Ovulation (please select): YES ◯ NO ◯

Describe any Menopause/Perimenopause symptoms: