Nutrition and Medical History/Assessment

Please complete this form before your first visit to maximize the time we have together. If information is not applicable or you are uncomfortable answering any questions, you may leave them blank and/or discuss them with me in person.

Date _____
Name _____ Date of birth _____ Age_____

Healthcare Team (please print clearly)

Present primary care provider (Name, Credentials):

_____

How long have you been working with this provider?_____

Other healthcare practitioner(s) and length of time you have been working with them:

_____
_____
_____
_____

Nutrition History (please print clearly)

Reason for seeking nutrition services:

_____
_____
_____

What goals do you hope to achieve through nutrition service?

_____
_____
_____

Have you worked with a nutrition professional before?

_____
_____
_____

Where do you get most of your nutrition information from?

_____
_____
_____

List the diets you have tried or are curious about?

Book title, diet, or program	Brief description
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Medical History (please print clearly)

Health Concerns/Diagnosed Medical Conditions (please list in order of importance to you)

_____
_____
_____
_____
_____

Medications & dose:

_____
_____
_____
_____
_____

Supplements (vitamins, herbs, etc):

_____
_____
_____
_____
_____

Known Allergies:

Drugs_____Foods_____
Animals_____Other_____

Hospitalizations and Surgeries (Type, Year):

_____
_____

Does anyone in your immediate family have any of the following health conditions? If so whom?

Heart Disease_____ Depression _____
Diabetes _____ Anxiety _____
Alcohol/Drug Addiction _____ Mental Illness_____
Cancer _____ Eating Disorder _____
High blood pressure _____ Rheumatoid Arthritis_____
High blood sugars _____ Food allergies _____
Poly Cystic Ovarian Syndrome _____ Colitis/Crohn's _____
Celiac Spruce Disease _____ Other Autoimmune Disease_____
Kidney Disease _____ Osteoporosis/Osteopenia _____
Liver Disease _____ Thyroid problems _____
Fructose Intolerance _____

Do you have or have you experienced any of the following. Check next to yes or no?

	Yes	No
Hair loss		
Dry skin		
Dizziness		
Fatigue		
Fainting spells		
Headaches		
Hypoglycemia		
Difficulty Sleeping		
Acne/Skin problems		
Dark skin patches		
Brittle Nails		
Bruising		

	Yes	No
Esophageal reflux		
Stomach aches		
Constipation		
Diarrhea		
Bloating		
Cold intolerance		
Irregular menses		
Abnormal lab values (if yes please describe which labs)		

_____

_____

Lifestyle and Habits

How many hours a day would you estimate that you spend doing the following:
Sleep_____ Work _____
Relax_____What form(s)?_____

_____

_____

If you participate in exercise list the type, duration, and amount of days per week.

_____

_____

_____

How long have you been on this exercise program?_____

_____

_____

_____

What is you current and past participation in sports or athletics?_____

_____

_____

_____

Did or do you ever exercise compulsively?_____
What other activities or hobbies do you enjoy doing?

_____

_____

_____

_____

Do you smoke? ○ Yes ○ No
If you have ever smoked, for how long? _____How much per day? _____

If you use recreational or illicit drugs what type? _____

Weight History (please print clearly)

Height_____
Low weight:_____ Age:____How long were you at this weight?_____
High weight:_____ Age:____How long were you at this weight?_____
Usual weight:_____ How long were you at this weight?_____

How do you feel about your weight/body now?

_____
_____
_____

Eating Behaviors

Number of meals per day: _____ Snacks:_____
Who plans your meals? Cooks? Shops? _____
_____
_____

How many meals per week do you usually eat out? (Including those prepared by a commercial food service, restaurant, deli, or fast food provider).

_____
_____
_____

What are some of your favorite places to go out to eat?

_____
_____
_____

What are your favorite foods?

_____
_____
_____

Do you currently eat these foods?_____ If not, why?_____
_____
_____
_____

Foods restricted from diet, and for how long:

Are there foods you would label as "good"?

Are there foods you would label as "bad"?

Describe any bad reactions you get from specific foods:

Do you crave any of the following? If yes which one(s) and what time of the day or month do the cravings occur? Sugar, starches, breads, chocolate, caffeine, salt, fat, vegetables, fruit.

How do you feel about your current diet?

What would you like to change about your current diet? Why?

What does your diet pattern look like on a typical day?

Time	Place	Food	Amount	Feelings

How much water do you drink per day? _____
How much alcohol do you drink a day? _____ a week? _____

How much coffee do you drink a day? _____ a week? _____

How much tea do you drink a day? _____ a week? _____

How much soda do you drink a day? _____ a week? _____

Other concerns, expectations, or goals for your care that you have not had an opportunity to discuss elsewhere:

_____
_____

_____
Patient Name (printed) Date

_____
Signature of Patient/Parent/Guardian