PERSONAL HISTORY

Date: _____ Name: _____ SS#: _____

Address: _____ City: _____ State: ___ Zip: _____

Home Phone: (____) _____ Business Phone: (____) _____ Cell Phone: (____) _____

Birth date: _____ Sex: M F e-mail: _____

Business/Employer: _____ Type of Work: _____

Check one: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated Number of Children: _____

Name of Emergency Contact: _____ Phone Number: (___) _____

Referred to this office by: _____

Purpose of this appointment: _____

PAST HEALTH HISTORY

Have you been treated for any conditions in the past year? ☐ Yes ☐ No If yes, please explain: _____

_____

Date of Last Blood Test: _____ Date of Last Physical Exam & Drs name: _____

What medications are you currently taking (please list for what condition/dosages): _____

_____

Do you currently take any Vitamins, Minerals, or Herbal supplements? ☐ Yes ☐ No

If yes, please list dosages/frequency: _____

Have you seen a Dietician/Nutritionist before? ☐ Yes ☐ No If yes, please explain: _____

What is the purpose of your consultation today: (check all that apply)

□ Gain weight
□ Lose weight
□ Eat healthier
□ Other, please describe: _____
□ Have more energy
□ Gain general nutrition knowledge
□ Treat a particular condition

PLEASE INDICATE IF YOU HAVE HAD A HISTORY OF ANY OF THE FOLLOWING:

□ Diabetes	□ Arteriosclerosis	□ Diarrhea	□ High Cholesterol	□ Osteoporosis
□ Cancer	□ Arthritis	□ Eating Disorders	□ IBS	□ Thyroid disorders
□ Heart Disease	□ Celiac Disease	□ Fatigue	□ Insomnia	□ Ulcers
□ Anemia	□ Changes in Stool	□ Headaches	□ Lactose Intolerance	□ Vomiting
□ Acid Reflux	□ Constipation	□ High Blood Pressure	□ Nausea	□ Other

PLEASE INDICIATE IF ANY MEMBER OF YOUR IMMEDIATE FAMILY HAS HAD A HISTORY OF ANY OF THE FOLLOWING:
(please specify which member of your family).

	Mother	Father	Brother	Sister
□ Diabetes				
□ Cancer				
□ Heart Disease				
□ Anemia				
□ Osteoporosis				

DIETARY HABITS

Current Weight: _____ lbs. Desired Weight:_____lbs. Height: _____inches Age: _____ years

What do you feel will be your biggest nutritional challenge? _____

_____

How many meals do you consume per day? _____

Do you ever skip meals, go on fasts or cleanses or use diet pills? ☐ Yes ☐ No If yes, please explain: _____

_____

How often do you eat out per week? _____ times per week. What types of restaurants do you frequent? _____

How do you prepare your food? _____

How many ounces of water do you consume per day (one bottle of water = .9 ounces)? _____

What food(s) would you have a hard time giving up? _____

What beverage(s) would you have a hard time giving up? _____

Do you have any dietary limitations (cultural, ethnic, religious, etc.)? ☐ Yes ☐ No If yes, please explain: _____

_____

Do you have any known food allergies (peanuts, tree nuts, milk, eggs, fish, shellfish, wheat, soy, etc.)? ☐ Yes ☐ No

If yes, please explain: _____

Do you have any known food intolerances (lactose, gluten, etc.)? ☐ Yes ☐ No If yes, please explain: _____

Do you drink alcohol? ☐ Yes ☐ No If yes, how many drinks do you consume per week? _____ drinks.

Do you smoke? ☐ Yes ☐ No If yes, how many packs per day: _____ How long have you smoked? _____ years.

Do you exercise? ☐ Yes ☐ No If yes, please describe routine/frequency: _____

What is your current stress level? ☐ No stress ☐ Low Stress ☐ Moderate Stress ☐ High Stress

Approximately how many hours do you sleep per night? _____ hours

****

I affirm that all statements made on these forms are true to the best of my knowledge. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment on the day services are performed.

Patients Signature X _____ Date _____

Legal Guardian if patient is a minor _____

Relationship _____

Thank you for your patience and cooperation.
We look forward to working with you!