



**Patient Information**

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Name: \_\_\_\_\_ S.S.#: \_\_\_\_ - \_\_\_\_ - \_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Home Phone: ( \_\_\_\_ ) \_\_\_\_\_ Work Phone: ( \_\_\_\_ ) \_\_\_\_\_ Occupation: \_\_\_\_\_  
 Name & Address of Employer: \_\_\_\_\_  
 Age: \_\_\_\_\_ Birth date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Pregnant? ( ) Y ( ) N  
 Marital Status: M S W D Spouse's Name: \_\_\_\_\_ # of Children \_\_\_\_\_  
 Who Referred You?: \_\_\_\_\_

**Health Information**

**Have you had Nutritional Counseling Before? ( ) Yes ( ) No**

Please list the FIVE main Conditions you want addressed regarding Nutrition. *(In order of importance)*

- 1.) \_\_\_\_\_
- 2.) \_\_\_\_\_
- 3.) \_\_\_\_\_
- 4.) \_\_\_\_\_
- 5.) \_\_\_\_\_

Please give a brief history of former treatments *(within 3 years)* for above complaints: \_\_\_\_\_

Do any of these conditions affect your work? ( ) Y ( ) N Your Family or Social Life? ( ) Y ( ) N

Have you had a medical diagnosis by a Medical Doctor? ( ) Y ( ) N Any recent Labs? ( ) Y ( ) N

If Yes, what was the diagnosis? \_\_\_\_\_

Are you taking any medications? ( ) Y ( ) N If Yes, list the medications: \_\_\_\_\_

Prior Surgery? \_\_\_\_\_

Date of your last physical examination by your primary care physician: \_\_\_\_\_

**Health Checklist (Check any of the following you have had):**

- |  |                                       |  |   |                                    |
|--|---------------------------------------|--|---|------------------------------------|
| <input type="checkbox"/> Scarlet Fever   | <input type="checkbox"/> Small Pox    | <input type="checkbox"/> Pneumonia       | <input type="checkbox"/> Cancer           | <input type="checkbox"/> Goiter    |
| <input type="checkbox"/> Diphtheria      | <input type="checkbox"/> Chicken Pox  | <input type="checkbox"/> Stroke          | <input type="checkbox"/> Yeast / Fungus   | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Typhoid Fever   | <input type="checkbox"/> Malaria      | <input type="checkbox"/> Influenza       | <input type="checkbox"/> Alcoholism       | <input type="checkbox"/> Epilepsy  |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Low Blood Sugar | <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> Anemia    |
| <input type="checkbox"/> Measles         | <input type="checkbox"/> Polio        | <input type="checkbox"/> Whooping Cough  | <input type="checkbox"/> Diabetes         |                                    |
| <input type="checkbox"/> Mumps           | <input type="checkbox"/> Arthritis    | <input type="checkbox"/> Asthma          | <input type="checkbox"/> Heart Disease    |                                    |

**Do You Currently Have Any:**

- |  |   |  |  |                                      |
|--|---|--|--|--------------------------------------|
| <input type="checkbox"/> Headaches         | <input type="checkbox"/> Gas / Bloating     | <input type="checkbox"/> Circulatory Problems    | <input type="checkbox"/> Sinus Trouble             | <input type="checkbox"/> Depression  |
| <input type="checkbox"/> Neck Pain         | <input type="checkbox"/> Constipation       | <input type="checkbox"/> High / Low B.P.         | <input type="checkbox"/> Earaches                  | <input type="checkbox"/> Fatigue     |
| <input type="checkbox"/> Arm/Shoulder Pain | <input type="checkbox"/> Abdominal Problems | <input type="checkbox"/> Vaginal Discharge       | <input type="checkbox"/> Poor Memory               | <input type="checkbox"/> Insomnia    |
| <input type="checkbox"/> Back Pain         | <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> Hot Flashes             | <input type="checkbox"/> Dizziness                 | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> Hip/Leg Pain      | <input type="checkbox"/> Colitis            | <input type="checkbox"/> Yeast / Fungus problems | <input type="checkbox"/> Numbness                  | <input type="checkbox"/> Allergies   |
| <input type="checkbox"/> Swollen Joints    | <input type="checkbox"/> Heart Trouble      | <input type="checkbox"/> Kidney/Bladder problems | <input type="checkbox"/> Mental Disorder           | <input type="checkbox"/> Overweight  |
| <input type="checkbox"/> Loose Stool       | <input type="checkbox"/> Heart Palpitation  | <input type="checkbox"/> Lung/Bronchial problems | <input type="checkbox"/> Cold/Tingling Extremities |                                      |

Habits: (Please mark with "F" -frequent, "M" -moderate, or "N" -never)

\_\_\_ Alcohol \_\_\_ Drugs \_\_\_ Tobacco \_\_\_ Coffee \_\_\_ Tea \_\_\_ Sweets

**Patient Agreement**

*Payment for services is expected at time of consultation. You understand that I provide nutritional consultation only. Insurance will not pay for nutritional consultation services; please do not ask us to fill out insurance claims forms.*

Signature \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_