Initial Nutrition Patient Intake Form

Patient Name:_____ **Date:**_____

Address:_____ **City/State/Zip:**_____

Primary Phone: _____ **Secondary Phone:** _____

DOB:_____ **Sex:** Male or Female **SSN#:**_____

Occupation: _____ **Employer:**_____

Primary diagnosis/chief complaint: _____

What would you like to gain from an appointment with a nutritionist: _____

_____

_____

Have you ever been told by a doctor that you have diabetes? Yes or No **If yes what age:**_____

Height: _____ **Weight:** _____

Activity Level (check only one) **Blood Type:** A AB AB O

- Sedentary (little or no exercise, desk job or bed ridden)
- Lightly Activity (light exercise- sports 1-3 days a week)
- Moderate Activity (moderate exercise- sports 3-5 days a week)
- Very Active (hard exercise- sports 6-7 days a week)
- Extra Active (hard daily exercise- sports and physical job)

If Pregnant- Trimester: 1 2 3

Food Allergies or Sensitivities (check all that apply):

_____Bananas
_____Chocolate
_____Citrus Fruits
_____Corn
_____Dairy
_____Eggplant
_____Eggs
_____Gluten Foods
_____Gluten Foods (highest)
_____Peanuts
_____Peppers
_____Refined Sugars
_____Shellfish
_____Soy
_____Strawberries
_____Sulfites
_____Tomatoes
_____Other_____

Vegetarian Intolerances (check all that apply)

_____Red Meat _____Poultry _____Fish _____Dairy _____Eggs

Organs or Systems needing support (check all that apply)

_____Adrenals	_____Gallbladder	_____Liver	_____Prostate
_____Bladder	_____Gums/Teeth	_____Lungs	_____Skin
_____Bones	_____Hair/Scalp	_____Male Reproductive Organs	_____Spine
_____Brain/Nerves	_____Heart	_____Mammary Glands/Breasts	_____Spleen
_____Bronchi	_____Intestines	_____Muscles	_____Thyroid
_____Ears	_____Joints	_____Nails	_____Uterus
_____Vision	_____Kidneys	_____Pancreas	_____Veins
_____Female Reproductive Organs		_____Pituitary Gland	

Current Medications (name & reason) _____

_____

Medication Allergies : NO YES if yes, please list_____

Surgeries (birth to present)_____

Preferred Language:_____ **Race:**_____ **Ethnicity** _____

Smoking Status: Current Past Never Unknown

**I affirm that the information I have given is correct to the best of my knowledge, and that is my responsibly to inform this office of any changes in my medical status.

_____

Signature Date