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 is your goal or what are you hoping to achieve from this appointment:

_____

_____

Have you received professional treatment for this condition: YES NO

If yes, with whom: _____

Date of Last Physical Exam: _____

Date of Last Lab Panel: _____

Has this condition affected your sleep quality or your ability to sleep? YES NO

Has this condition affected your appetite? YES NO

List anything that aggravates your condition: _____

_____

List anything that relieves or improves your condition:_____

_____

When did you first notice this condition OR when were you first diagnosed with this condition: _____

_____

Height: _____ **Weight:** _____

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

Non-Medication Allergies: _____

Current Vitamins, Minerals, Supplements, etc.… _____

_____

Current Medications (name & reason) _____

_____

Medication Allergies : NO YES if yes, please list_____

Surgeries (birth to present)_____

_____

Social History and Life Choices (select the best answer):

Alcohol:
Daily Weekly Occasionally Never

Caffeinated Drinks:
Daily Weekly Occasionally Never

Energy Products/Stimulants:
Daily Weekly Occasionally Never

Drugs:
Daily Weekly Occasionally Never

Fresh/Homemade Foods:
Daily Weekly Occasionally Never

Packaged/Processed Foods:
Daily Weekly Occasionally Never

Restaurant/Takeout Foods:
Daily Weekly Occasionally Never

Tobacco
Daily Weekly Occasionally Never

Water (include how many glasses): _____
Daily Weekly Occasionally Never

For Women Only (only for women over 16 years of age):

Are you pregnant? YES NO

Are you nursing? YES NO

Are you taking birth control? YES NO

If yes, is it an oral one? YES NO

Do you have irregular periods? YES NO

Are your periods painful? YES NO

Are you in perimenopause? YES NO

Are you in menopause? YES NO

Do you take hormone replacement therapy? YES NO

Medical History (if multiple choices, please select all that apply):

General: ◯ allergies ◯ fatigue ◯ fainting ◯ anemia ◯ HIV/AIDS ◯ gallbladder problems ◯ weight loss/weight gain ◯ eating disorder ◯ thyroid problems ◯ liver problems ◯ cancer (type)_____ ◯ diabetes (type) _____ ◯ rash/Rosacea ◯ eczema/dermatitis/psoriasis/dry skin ◯ acne

Muscle/Joint: ◯ arthritis ◯ rheumatoid arthritis (RA) ◯ neck pain ◯ mid back pain ◯ lower back pain ◯ joint pain (i.e. knee, wrist) _____ ◯ fibromyalgia ◯ gout ◯ scoliosis ◯ osteopenia/osteoporosis

Cardiovascular: ◯ high blood pressure ◯ heart attack ◯ stroke ◯ rapid heartbeat ◯ chest pains ◯ aneurysm ◯ poor circulation ◯ high cholesterol ◯ congestive heart failure

Neurological: ◯ concussion ◯ ADD/ADHD ◯ OCD ◯ seizures ◯ drug/alcohol dependence ◯ arm/hand tingling (which side) _____ ◯ balance problems ◯ loss of smell ◯ loss of taste ◯ foggy brain/poor concentration ◯ headaches/migraines ◯ dizziness ◯ anxiety ◯ depression

GI: ◯ constipation/irregular bowel habits ◯ diarrhea ◯ IBS ◯ Crohn's ◯ Celiac's ◯ ulcer ◯ heartburn/acid reflux ◯ abdominal pain ◯ hemorrhoids ◯ "Leaky Gut" ◯ gas/ bloating

Respiratory: ◯ asthma ◯ emphysema ◯ chronic cough ◯ shortness of breath ◯ COPD

Genitourinary: ◯ frequent/painful urination ◯ bladder infection ◯ kidney stones ◯ prostate problems ◯ loss of bladder control ◯ PMS ◯ endometriosis ◯ breast lumps ◯ Profuse/irregular menstrual flow ◯ chronic yeast infections ◯ kidney infection

EENT: ◯ chronic sinusitis ◯ difficulty swallowing ◯ ringing in the ears/tinnitus ◯ vision problems

**"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