New Patient Nutrition Consult Information

Name_________________________________ **Date**_____________

Address____

City_____________________ **State**________ **Zip**______________

Home #______________ **Cell#**_________ **Work#**________________

E-Mail___________________________ **Occupation**_____________

Referred By_______________________ **D.O.B.**__________________

What is your main complaint or area of interest? **What is your anticipated goal?**

____

____

Family History (check all that apply and indicate family member):

Stroke___
High BP___
Depression___
Heart Disease__
Arthritis (RA or OA) _____
Cancer___ Type? ___________
Diabetes Type I or Type 2 ___
Weight Problems___
Stomach Ulcer___
Psoriasis___
Renal Impairment___

Personal History (check all that apply):

Arthritis__	Thyroid Problems __
RA __	Hypothyroidism __
OA __	Hyperthyroidism __
Stroke __ Date___	Headaches __
High Cholesterol ___	Chronic Tension __
How High? ______	Migraines __
High Blood Pressure__	Cluster __
How High? ______	Hormonal Imbalances __
Diabetes __	Food Allergies __
Fasting Blood Sugar level avg _____	To What? ______________
2 Hour Post-Meal Blood Sugar level avg_____	Seasonal Allergies __
Metabolic Syndrome __	To What? ______________
Insulin Resistance __	Medication Allergies __
Low Blood Sugar __	To What? ______________
Chronic Fatigue __	Sleep Problems __
Fibromyalgia __	Forgetfulness or “Brain Fog” __

Personal History Cont. (check all that apply): Frequent Colds/Flu __ Cancer __ What type? ____________________________ Chemo? _______________________________ Radiation? Steroids? Surgeries __ What type? ____________________________	Hot Flashes __ PMS __ Birth Control Pills/ Hormones __ Weight Problems __ Recent Weight Loss/ Gain How much in pounds? _____ Over what timeframe? _____ Constipation __ Diarrhea__ Abdominal Cramping/ Bloating __ Yeast Infections __ Low Libido __ Ulcers __ No Appetite __ Moderate Appetite __ Strong Appetite __ Nausea __ Vomiting __

What Medications and Dosages are you taking? List all please:

____

____

What Vitamins and herbal supplements are you taking? List all please:

____

____

Do you eat, drink, or use (circle all that apply):

Antacids
Aspirin
Tylenol
Ibuprofen
Laxatives
Refined Sugars
Margarine
Chewing Gum
Salt (w/out tasting)
Artificial Sweeteners (Blue, Pink, Yellow)

Protein Drinks
Alcohol
Tap Water
Bottled Water
Tea
Candy
Butter
Fried Foods
Tobacco

Appetite Suppressants
Coffee
Decaf Coffee
Diet Soda
Soda
White Bread
Fast Foods
Chips
Cigarettes
Coffee Creamers

List any food aversions and/or foods you dislike:

____

____

Provide how many (8 ounces per cup) of fluids to you drink per day?

____

How often do you exercise (hours per week) and what activities do you prefer?

____

Do you get noticeably irritated, weak, or lightheaded if you haven't eaten in a while?

____

Do you crave certain foods? **_Yes or No_ (check all that apply)**

Which foods: Sweets? Chocolate? Bread/Pasta?

Fried Foods? Alcoholic drinks? Sodas/Diet Sodas? Meat?

Other: ____

Are you experiencing any of the following?

Under excessive amounts of stress_____ at home______ at work___________

Physical Stress________ Mental Stress_________

Exposed to chemicals regularly_________________

Type________________________________

Exposed to smoke regularly___________________

How often do you have bowel movements? __________per day/ week/ month

Urinate? _________ per day

How is your dental health? Prone to Cavities? Gum Disease? Bleeding Gums? Dentures/Partials?

____

Are your nails weak or brittle? _____________________________________

Average Hours of Sleep per night? __________________________________

Any sleeping problems? ____

____

Describe your daily routine from wake to sleep?

____

____

What kitchen appliances do you often use when preparing your food at home?

____

Do you meal prep? ___ if so, how often? ___________________________

Where do you do your grocery shopping and how often?

____

To what extent will you commit to achieving better health?

Little________ Moderate ________ Major_________ Extreme________

Is there anything else about either your history or your current condition that you feel is important to mention?

____

____

____

(FOR DIETITIAN USE ONLY- PLEASE DO NOT WRITE BELOW)

____

Age:	Wt:	Ht:	BP:

For Weight Management Patient Measurements:

Chest: ________
Waist: _________
Hips: _________
Right Arm: ________
Left Arm: ________
Right Thigh: ________
Left Thigh: _________
Right Calf: _________
Left Calf: ________

Fat % ________
BMI ________

Current Caloric Intake: _______________________
Required Caloric Intake: ______________________

Nutrient Breakdown:

Notes: