Nutrition Therapy – New Patient History

All information received in this form will be treated as confidential. Please fill out the form ***completely and accurately***. This information will help our dietitian to develop nutrition therapy to address your needs, goals and interested and is safe and effective.

Demographics					
First Name:		Middle:		Last:	
Date of Birth:		Gender:			
Address:					
City, State, Zip:					
Preferred Phone:					
Referred by:					
Marital Status:					
Living with:	□ Family	□ Friends	□ Alone		
Number of Persons in Household:		Number of Children in Household:			

Concerns
What health and/ or nutrition concerns would you like to focus on during your visit?
1.
2.
3.

Medical History			
Please check "yes" for all medical conditions that apply.			
Condition	**Yes**	**Condition**	**Yes**
Cardiovascular		**Musculoskeletal**	
Heart Attack/ Angina		Lupus/ SLE	
High Blood Pressure		Fibromyalgia	
Arrhythmia/ Palpitation		Arthritis	
Heart Failure/ CHF		Osteoporosis	
Heart Surgery		**Endocrine**	
Stents/ Angioplasty		Type 1 Diabetes	
Peripheral Vascular Disease		Type 2 Diabetes	
Gastrointestinal		Thyroid disorder	
Ulcer/ Gastritis		Menstrual Disorder	

Acid Reflux/ GERD		Hypoglycemia	
Ulcerative Colitis		Polycystic Ovarian Syndrome	
Crohn's Disease		**Respiratory**	
Inflammatory Bowel Disease		Asthma	
Celiac Disease		COPD	
Diarrhea		Sleep Apnea	
Constipation		**Mental Health**	
Nausea/ Vomiting		Anxiety	
Irritable Bowel Syndrome		Depression	
Diverticular Disease		Bipolar Disorder	
Hematologic		Schizophrenia	
Anemia		Dementia	
Blood Clots		ADD/ADHD	
Sickle Cell Disease		Anorexia Nervosa	
Lyme Disease		Bulimia	
MRSA		Binge Eating Disorder	
HIV/ AIDS		Unspecified Eating Disorder	
Hepatitis A B C		**Oncology**	
Neurological		Cancer	
Stroke/ TIA		Type:	
Seizures			
Neuropathy		Treatment:	
Concussion			
Multiple Sclerosis			

Other Medical or Surgical History:

Allergies:

Medications and Vitamin/ Mineral Supplements (Current): Please list ALL medications, including over the counter, herbs, and vitamin/ mineral supplements:

Medication/ Supplement	**Dosage**	**Frequency**

Have you had prolonged or regular use of NSAIDS (Ibuprofen, Aleve, Aspirin, etc)? □Yes □No
Have you had prolonged or regular use of Tylenol (acetaminophen)? □Yes □No
Have you had prolonged or regular use of acid-blocking drugs (Zantac, Pepcid, etc)? □Yes □No
Have you taken antibiotics >3 times per year? □Yes □No
Have you been on antibiotics long term (> 1 month continuously)? □Yes □No

Nutrition History

Have you ever had an appointment with a dietitian or nutritionist? □Yes □No
Has your doctor recommended that you follow a specific eating plan? □Yes □No
Have you changed your eating habits for a health reason? □Yes □No If yes, please explain:
Do you follow any special diet or have diet restrictions or limitations for any reason (health, cultural, religious, other)? □Yes □No If yes, please explain:

Check all that apply:

□ Low Fat	□ Low Carbohydrate	□ High Protein
□ Low Sodium	□ Diabetic	□ No Dairy
□ No Wheat	□ Gluten Free	□ Vegetarian
□ Vegan	□ Specific Program for weight loss/ maintenance:	
□ Other:		

Do you avoid any particular foods? □Yes □No If yes, please explain:
Do you have any adverse food reactions (intolerance or allergy)? □Yes □No Please explain:
Do you weigh yourself? □Yes □No If so, how often?
Has your weight changed in the past 3-6 months? □Yes □No If so, please specify:

Current Weight:	Usual Weight:	Desired Weight:

Surgical and Non-surgical Weight Loss Patients Only:

Highest adult weight:	Lowest adult weight:	Weight 1 year ago:

What is the most weight you have been able to lose at one time?
How?

Please list all weight loss methods tried in the past. Please be as specific as possible (eg. SlimFast, Weight Watchers, working with a dietitian or doctor, meal replacement, medications, etc.):

Weight Loss Method	Time following program	Length of time loss maintained	Reason for stopping	Problems during program
Example: SlimFast	*2 months*	*1 month*	*Felt hungry*	*Fatigue*

Do you have or have you had an eating disorder? □Yes □No If yes, please explain:

How many meals do you eat each day?	How many snacks per day?

How many times do you eat out in a week? And where?

Who does most of the food shopping and preparation?

Do you read food labels? □Yes □No What do you look for?

Do you drink alcohol? □Yes □No If yes, how many drinks per week:

Do you drink caffeinated beverages? □Yes □No If yes, how many cups per day:

Please circle all the types of beverages you may drink over the course of a week:
Juice/ Fruit Drinks Regular Soda Diet Drinks Milk Coffee Tea Water

Check all of the factors that apply to your eating habits and current lifestyle:

□ Love to eat	□ Fast eater	□ Eating in the middle of the night
□ Love to cook	□ Erratic eating patterns	□ Do not plan meals or menus
□ Emotional eater	□ Eat too much	□ Eat too little
□ Late night eater	□ Rely on convenience foods	□ Travel frequently
□ Struggle with eating issues	□ Eat fast food frequently	□ Eat only because I have to
□ Family members have different tastes	□ Non-availability of nutritious foods	□ Negative relationship with food
□ Dislike cooking	□ Confused about food/ nutrition	□ Don't know how to cook
□ Eat too much under stress	□ Eat too little under stress	□ Time constraints

Any other challenges you consider with your diet:

Have you ever been concerned about being able to afford meals for you and your family? □Yes □No		
Lifestyle Information		
Do you use any nicotine/ tobacco products? □Yes □No		
How many years?	Packs per day:	
Are you currently or have you used any recreational drugs? □Yes □No If yes, list types:		
Do you engage in physical activity on a regular basis? □Yes □No If yes, what kind?		
Activity	**Number of Days per Week**	**Duration (minutes)**
How many hours do you normally sleep per night?		
How do you handle stress? What helps you relax?		

Patient Use Only: I certify that the above information is correct to the best of my knowledge.

_____ _____

Patient Signature Date

Intake Form Reviewed By: _____

Signature of Dietitian