NEW CLIENT INFORMATION

NAME:	INITIAL APPOINTMENT DATE:
Date of Birth: ____/____/____ Age:	GENDER:
CONTACT INFORMATION	
ADDRESS:	
CITY/STATE:	ZIP:
HOME PHONE:	CELL PHONE:
E-MAIL:	
CLIENT INFORMATION	
EDUCATION LEVEL:	MARITAL STATUS:
OCCUPATION:	PART-TIME or FULL-TIME
CHILDREN: (Specify Gender/Age)	
PARENT/GUARDIAN OR EMERGENCY CONTACT INFORMATION	
PARENT/GUARDIAN (IF <18 YEARS OLD) OR EMERGENCY CONTACT NAME:	
ADDRESS:	
CITY/STATE/ZIP:	
HOME PHONE:	CELL PHONE:

PREFERRED METHOD OF CONTACT: (CIRCLE ONE) HOME CELL TEXT E-MAIL

DO YOU WISH TO RECEIVE OUR NEWSLETTER? (CIRCLE ONE) YES NO

HOW DID YOU HEAR ABOUT US?

- ☐ E-Mail
- ☐ Friend/Relative
- ☐ Work
- ☐ PsychologyToday
- ☐ HealthProfs
- ☐ Insurance Company
- ☐ Internet
- ☐ Other (please specify) _____

Primary Reason/Goal for Nutrition Counseling: _____

_____

_____

MEDICAL HISTORY			
HEIGHT:	CURRENT WT:	USUAL WT:	DESIRED WT:

Please indicate whether you or a family member have/had any of the following conditions:

CONDITION	**SELF**	**FAMILY** (Specify	**TREATMENT/INFO**
Asthma			
Cancer			
Cardiovascular Disease			
Diabetes/Insulin Resistance			
Drug Dependency			
Eating Disorder			
Food Allergy/Intolerance			
Fibromyalgia			
Kidney Disease			
High Cholesterol			
Hypertension			
IBS/Crohn's/Celiac's			
Menstrual Irregularities			
PCOS			
Obesity			
Orthopedic/Joint Problems			
Thyroid Disorder			
Vitamin Deficiency			
Mental Health Condition			
Other			
ARE YOU CURRENTLY BEING TREATED FOR ANY MEDICAL CONDITIONS?			
HAVE YOU EVER BEEN ADVISED BY YOUR PHYSICIAN TO FOLLOW A SPECIAL DIET?			
DO YOU HAVE ANY RELIGIOUS BELIEFS THAT IMPACT YOUR DIETARY INTAKE?			
LIST CURRENT PRESCRIPTIONS & OTC MEDICATIONS:			
LIST CURRENT VITAMINS/MINERALS/SUPPLEMENTS:			

THE ABOVE INFORMATION IS ACCURATE TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT THIS INFORMATION IS NECESSARY FOR PROVIDING ME WITH APPROPRIATE NUTRITION GUIDANCE.

SIGNATURE CLIENT OR GUARDIAN: DATE:

MENSTRUAL HISTORY: *(Female Patient)*

Are you currently menstruating? _____ Yes ____ No ____ Have never menstruated

At what age did you get your first period? _____

Date of last menstrual cycle: _____ Are your periods regular? _____ Yes ____ No

MISCELLANEOUS SYMPTOMS:

Do you now or have you ever experienced (for each checked, please add details to explain):

_____ Cold intolerance _____

_____ Tingling sensation in hands or feet _____

_____ Headaches _____

_____ Lightheadedness/Dizziness _____

_____ Sleeping difficulties _____

_____ Hair loss _____

_____ Hair growth on face and/or chest _____

_____ Chest pains or Rapid heart beat _____

_____ Shortness of breath _____

_____ Mood swings _____

_____ Confusion or Difficulty concentrating _____

_____ Memory problems _____

_____ Anxiety, especially around food _____

_____ Less social interaction with family _____

_____ Problems with teeth _____

_____ Sore throat _____

_____ Taste changes _____

_____ Constipation or Diarrhea _____

_____ Muscle or Joint pain _____

_____ Obsessive-compulsive behaviors _____

_____ Other (explain) _____

Goals/Expectations:

What do you think is your most serious nutrition habit/problem? _____

_____

Any other information you think may be important for me to know: _____

_____

Do you want to change your eating habits? _____Yes _____ No

Why? _____

Did you have any expectations from coming to see the nutritionist today? _____Yes _____ No

Please explain: _____