# Patient Initial Assessment for Nutrition Counseling

Date:

| Name | | | | |
|---|---|---|---|---|
| Date of Birth | | Age: | Gender: M F | |
| Address | | | | |
| City, State, Zip code | | | | |
| Phone | Cell: | Home: | Work: | |
| Email | | | | |
| Best way to contact? | Email Phone | Leave a message? Y N | | |
| Primary Physician | Name: | Email: | City: | Phone: |
| Other Pertinent Provider | Name: | Email: | City: | Phone: |
| Referred by | | | | |

## Complaints/Concerns

What do you hope to achieve in your visit?

List your three main health/nutrition concerns:

1)
2)
3)

When was the last time you felt well?

Did something trigger your change in health?

What makes you feel better?

What makes you feel worse?

## Allergy Information

| List Food Allergies | |
|---|---|
| List non-food allergies (Meds/supplements) | |
| List environmental allergies | |
| What are the symptoms? | |

## Family History

Please note any family history of the following diseases: heart disease, cancer, stroke, high blood pressure, overweight, lung disease, diabetes, mental illness or addiction

| Family Member: | Health Condition: |
|---|---|
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## Medical History

Please check health conditions that your doctor has diagnosed and provide the date of onset.

Gastrointestinal

___ Irritable Bowel Syndrome
___ Inflammatory Bowel Disease
___ Chron's Disease
___ Ulcerative Colitis
___ Celiac Disease
___ Gastric or Peptic Ulcer Disease
___ GERD, reflux/heartburn
___ Hepatitis C or Liver Disease
Other:

Respiratory

___ Asthma
___ Chronic Sinusitis
___ Pneumonia
___ Sleep Apnea
___ Emphysema
Other:

Cardiovascular

___ Heart Disease
___ Stroke
___ Elevated Cholesterol
___ Irregular Heart Rate
___ High Blood Pressure
___ Mitral Valve Prolapse
Other:

Inflammatory/autoimmune

___ Chronic Fatigue Immune
___ Deficiency Syndrome
___ Autoimmune Disease
___ Rheumatoid Arthritis
___ Lupus
___ Poor Immune Function
___ Severe Infections Diseases
___ Herpes
___ Gout
Other:

Musculoskeletal/Pain

___ Osteoarthritis
___ Chronic pain
___ Fibromyalgia
___ Migraines
Other:

Cancer:

Please describe type and treatment:

Neurological/Brain

___ Depression
___ Anxiety
___ Autism
___ Seizures
___ Bipolar Disorder
___ ADD/ADHD
___ Multiple Sclerosis
Other:

Metabolic/Endocrine

___ Diabetes (Type 1 or 2)
___ Metabolic Syndrome
___ Hypoglycemia
___ Hypothyroidism
___ Hyperthyroidism
___ Polycystic Ovarian Syndrome
___ Infertility
Other:

Dermatological

___ Eczema
___ Psoriasis
___ Acne
___ Rosacea

Urinary/Gynecological

___ Kidney Stones
___ Urinary (UTI's)
___ Yeast infection

## Medications and Supplements

Please list all prescription medications and supplements, herbs/botanicals you are currently taking.

| Medication Name | Dose | Frequency | Reason |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| Supplement Name | Dose | Frequency | Reason |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Have you had prolonged or regular use of NSAIDS (Advil, Aleve, Motrin, Aspirin)? Yes No

Have you had prolonged use of Tylenol? Yes No

Have you had prolonged use of acid-blocking drugs (Zantac, etc)? Yes No

Frequent antibiotics >3X per year? Yes No Long term antibiotics? Yes No

## Nutrition History

| |
|---|
| Have you ever had a nutrition consultation? Yes No |
| Have you made any changes in your eating habits because of your health? Yes No (describe below) |
| Do you currently follow a special diet or nutritional program? Yes No (describe below) |
| Do you avoid any particular foods? Yes No (describe below) |

| Height: | Weight: | Desired weight: |
|---|---|---|
| Usual weight range: | Waist circumference: | |
| Have you had any recent history of weight loss or gain? (please describe) | | |
| Do you have (or had) an eating disorder? Yes No (describe below) | | |
| How many meals per day do you eat? | How many snacks? | |
| How many meals do you eat out per week? | | |
| Do you have any adverse food reactions (allergies or intolerances)? | Yes No (describe below) | |
| Do you drink alcohol? Yes No How many drinks per week? | | |
| Do you drink coffee or other caffeinated beverages? | Yes No How many drinks per day? | |

| Do you use any artificial sweeteners? Yes No (which ones?) |
| --- |
| Favorite foods: |

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

___ Fast Eater
___ Erratic eating patterns
___ Eat too much/overeat
___ Late night eating
___ Rely on convenience items
___ Love to eat
___ Love to cook
___ Family members have different tastes
___ Live or often eat alone
___ Time constraints
___ Struggle with eating issues
___ Emotional eater
___ Eat fast food frequently
___ Poor snack choices
___ Do not plan meals or menus
___ Eat because I have to
___ Negative relationship with food
___ Dislike healthy food
___ Travel Frequently
___ Confused about food/nutrition

## Lifestyle Information

List the exercise that you participate in weekly.

| Activity | Type/Intensity (low-high) | # of days per week | Duration (minutes) |
| --- | --- | --- | --- |
| Stretching/yoga | | | |
| Cardio/Aerobics | | | |
| Strength Training | | | |
| Sports or Leisure | | | |

Note any problems that limit your physical activity.

Do you smoke? Yes No

Daily Stressors: (rate on a scale of 1 (low) to 10 (high)

Work ____ Family _____ Social ____ Finances ___ Health ___ Other: _______

Average number of hours of sleep per night during the week:

Average number of hours of sleep per night during the weekend:

Trouble falling asleep? Yes No

## Readiness Assessment

On a scale of 1 (not willing) to 5 (very willing) answer the following questions.

In order to improve your health how willing are you to:

| | |
| --- | --- |
| Significantly modify your diet | |
| Take nutritional supplements each day | |
| Keep a record of everything you eat each day | |
| Modify your lifestyle (sleep, work, exercise) | |
| Practice a relaxation technique | |
| Engage in regular exercise/physical activity | |
| Have periodic lab tests to assess your progress | |