

Your health and well-being are influenced by many different things, including lifestyle, family history, emotional health, physical activity and nutrition/eating habits. Please complete the following assessment to the best of your ability to provide us an overall view of your general lifestyle and health.



NEW PATIENT NUTRITION ASSESSMENT

First Name _____ M.I. _____ Last Name _____

Address _____ City _____ State _____ Zip _____

Cell # _____ Birth Date ____ / ____ / ____ Age ____

Home # _____ E-Mail _____

Marital Status: Married / Single / Divorced Occupation _____

Do you have children? Yes / No Names & Ages of Children _____

Are you pregnant? Yes / No _____

Due Date: ____ / ____ / ____ _____

With whom do you live? (Include children, parents, relatives and / or friends and ages of each)

Emergency Contact Name _____ Relationship _____

Emergency Contact Phone: _____

Primary Care Provider _____ Phone _____

Other doctors / practitioners you see _____

GOALS and READINESS ASSESSMENT

I would like to visit with the nutrition counselor today because....

My overall health and wellness goals are:

- | | |
|--|---|
| <input type="checkbox"/> Create a healthy lifestyle | <input type="checkbox"/> Improve overall health |
| <input type="checkbox"/> Learn to balance activity and diet | <input type="checkbox"/> Advice on healthy habits / regimen |
| <input type="checkbox"/> Advice on disease prevention | <input type="checkbox"/> Learn how to reduce or eliminate medications |
| <input type="checkbox"/> Reduce stress | <input type="checkbox"/> Increase energy / activity level |
| <input type="checkbox"/> Weight management | <input type="checkbox"/> Anti-aging strategies |
| <input type="checkbox"/> Decrease body fat | <input type="checkbox"/> Improve athletic performance |
| <input type="checkbox"/> Supplementation advice based on my specific needs | <input type="checkbox"/> Improve balance / coordination |
| <input type="checkbox"/> Improve digestion | <input type="checkbox"/> Improve flexibility |
| <input type="checkbox"/> Feel better | <input type="checkbox"/> Reduce or eliminate muscle or joint discomfort |
| <input type="checkbox"/> Other _____ | |

If I could change three (3) things about my health and nutritional habits, they would be....

I am motivated by....

- | | |
|---|--|
| <input type="checkbox"/> Accountability | <input type="checkbox"/> Seeing results for my efforts |
| <input type="checkbox"/> Having fun | <input type="checkbox"/> Feeling better |
| <input type="checkbox"/> Praise / rewards | <input type="checkbox"/> Other _____ |

The biggest challenges to reaching my health and wellness goals is / are:

- | | |
|--|--|
| <input type="checkbox"/> Lack of motivation | <input type="checkbox"/> Time |
| <input type="checkbox"/> Lack of equipment | <input type="checkbox"/> Self – conscious |
| <input type="checkbox"/> Lack of knowledge (not knowing how or what to do) | <input type="checkbox"/> No support |
| <input type="checkbox"/> Lack of results (discouraged) | <input type="checkbox"/> Hitting a plateau |
| <input type="checkbox"/> Lack of energy | <input type="checkbox"/> Other _____ |

To Improve my health, I am READY / WILLING to...

- | | |
|--|--|
| <input type="checkbox"/> Significant modify my diet | <input type="checkbox"/> Take nutritional supplement daily |
| <input type="checkbox"/> Keep a record of everything I eat / drink | <input type="checkbox"/> Practice relaxation techniques |
| <input type="checkbox"/> Modify my lifestyle (work demands, sleep, activity) | <input type="checkbox"/> Engage in regular exercise / activity |

PAST MEDICAL HISTORY

Please indicate what DISEASE, SYMPTOM, INJURY, SURGERY or CONDITION you or a relative have been diagnosed with and / or for which treatment has been provided.

ILLNESS / SYMPTOM / INJURY / SURGERY	Date(s)	Age when diagnosed / treated	Describe / Specify
Allergies (specify type)			
Anemia			
Anxiety			
Arthritis			
Asthma			
Autoimmune condition (specify)			
Bronchitis			
Cancer			
Chronic fatigue syndrome			
Crohn's disease or Ulcerative Colitis			
Depression			
Diabetes (specify type)			
Dry, itchy skin, rashes, dermatitis			
Eczema			
Emphysema			
Epilepsy, convulsions, seizures			
Eye disease (specify)			
Fibromyalgia			
Food allergies or sensitivities (specify)			
Fungal infection			
Gall bladder disease/gallstones (specify)			
Gout			
Heart attack / angina			
Heartburn			
Heart disease (specify)			
Hepatitis			
High blood fats (cholesterol/triglycerides)			
High blood pressure (hypertension)			
Hypoglycemia (low blood sugar)			
Intestinal Disease			
Inflammatory Bowel Disease (specify)			
Irritable bowel syndrome			
Kidney disease			
Lung disease			
Liver disease			
Mononucleosis			
Osteoporosis			

ILLNESS / SYMPTOM / INJURY / SURGERY	Date(s)	Age when diagnosed / treated	Describe / Specify
PMS			
Polycystic Ovarian Syndrome			
Pneumonia			
Prostrate problems (specify)			
Psychiatric conditions (specify)			
Sinusitis			
Sleep apnea			
Stroke			
Thyroid disease			
Urinary tract infection			
Injury (specify)			
Operations (specify)			
Other (specify)			

List any medical symptoms you have experienced in the last 6 months in the following areas:

- | | |
|--|--|
| <input type="checkbox"/> Head _____ | <input type="checkbox"/> Eyes _____ |
| <input type="checkbox"/> Ears _____ | <input type="checkbox"/> Nose _____ |
| <input type="checkbox"/> Mouth/throat _____ | <input type="checkbox"/> Skin _____ |
| <input type="checkbox"/> Heart _____ | <input type="checkbox"/> Lungs _____ |
| <input type="checkbox"/> Digestive tract _____ | <input type="checkbox"/> Joint/muscle _____ |
| <input type="checkbox"/> Mind/mental _____ | <input type="checkbox"/> Emotions _____ |
| <input type="checkbox"/> Weight _____ | <input type="checkbox"/> Energy/Activity _____ |
| <input type="checkbox"/> Other _____ | <input type="checkbox"/> Other _____ |

To help identify any deficiencies or nutrients that may be out of “healthy” or “normal” range, would you like to meet with our nurse practitioner and have a blood panel ordered? () YES () NO
(in most, this is covered by insurance)

MEDICATION AND SUPPLEMENT INTAKE

Medication/Supplement	Why? For what?	Dose / Units	Frequency	Start Date	Stop Date

Do you have allergies to any medications, herbs or supplements? Yes / No

Please explain: _____

LIFESTYLE

PHYSICAL ACTIVITY

ACTIVITY	TYPE / INTENSITY (low-moderate-high)	DURATION (minutes)	# DAYS / WEEK

If you have been exercising regularly, what results or changes have you seen? _____

Do you have any physical limitations or is there anything that inhibits or limits your participation in an exercise program? YES / NO

Please explain _____

Are you interested in learning about options regarding a physical workout program? YES NO

Indicate daily stressor and rate the level of stress from 1 (extremely low) to 10 (extremely high):

Work ____ Family ____ Social ____ Financial ____ Health ____ Other _____

On average, how many hours of sleep per night do you get? Weekdays _____ Weekends _____

Do you smoke? () Never () In the past () Currently How long? _____

Alcohol use? () Never () In the past () Currently -Type/amount/frequency _____

Drug use? () Never () In the past () Currently – Type/Frequency _____

WEIGHT HISTORY

Would you like to be weighed and have measurements taken today? Yes No

Height: _____ Current Weight _____ Desired Body Weight _____

When were you last at your desired body weight? Age _____ Date: _____ (mo / year)

Have you had recent changes in your weight (within the last 0-6 months) that you are concerned about?
 YES NO If YES, please explain _____

DIGESTIVE HISTORY

- Do you associate any digestive symptoms with eating certain foods? Yes No

Please explain _____

- Do you associate any digestive symptoms with any other habits? Yes No

Please explain _____

- Do you associate any digestive symptoms with the environment / stress? Yes No

Please explain _____

- How often do you have a bowel movement? _____

Type (hard / loose / soft / runny) _____

- Please indicate how often you experience the following symptoms:

Heartburn	Often	Sometimes	Never
Gas	Often	Sometimes	Never
Bloating	Often	Sometimes	Never
Stomach Pain	Often	Sometimes	Never
Nausea / Vomiting	Often	Sometimes	Never
Diarrhea	Often	Sometimes	Never
Constipation	Often	Sometimes	Never

DIET HISTORY

- Do you follow a special diet / nutritional program (check if applicable)? If so, how long?

Low Fat _____ Low Carb _____ Low Sodium _____

No Gluten _____ No Dairy _____ High Protein _____

Vegetarian _____ Vegan _____ Diabetic _____

Weight Loss _____ Weight Gain _____ Other _____

- Which meals do you eat regularly? Time?

Breakfast _____ Lunch _____ Snacks _____ Dinner _____

- What liquids do you drink? How often? When?

Water _____ Tea _____ Coffee _____

Juice _____ Soda _____ Milk _____

Milk alt _____ Other _____ Other _____

- Do you eat any of the following? How often?

Organic fruit _____ Organic vegetables _____

Raw fruits / vegetables _____ Cooked vegetables _____

Fried foods _____ Fast foods _____

Convenience foods _____ Canned foods _____

Meats _____ Fish/seafood) _____

Dairy _____ Breads _____

Candies/sweets _____ Other _____

- Food Cravings: _____

- Food Dislikes: _____

I agree that all the information I have provided is true and accurate to the best of my knowledge.

Client Signature _____ **Date:** _____