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NEW PATIENT INFORMATION FORM

General Information

Name: _____ Date: _____
Age: _____ Date of Birth: _____ Gender: _____
Home Address: _____
Home Phone #: _____ Cell Phone #: _____
Occupation: _____ Marital Status: _____
Number of children: _____
Are you currently pregnant (include due date if yes)? ___ Y ___ N Due Date: _____
Who lives in your home? _____
Reason for appointment: _____

Goals and Readiness

My food and nutrition-related goals are: _____

My overall health goals are: _____

My biggest obstacle to achieving my goals is: _____

Please rate your willingness to do the following on a scale of 1 (not willing) to 5 (highly willing):

___ Keep a record of what you eat every day ___ Modify your lifestyle (sleep, work, cooking)
___ Significantly modify your diet ___ Engage in regular physical activity (if not already)

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Weight History

Height: _____ Current weight: _____ Desired weight: _____
Highest adult weight/age: _____ Lowest adult weight/age: _____
Have you had a recent weight change? __ Y __ N
If yes, please explain: _____

Medical History

Are you currently being treated by a physician for any medical conditions? __ Y __ N
If yes, please explain: _____

Please list any surgeries you have had and when: _____

Are you currently taking medication (over-the-counter or prescription)? __ Y __ N
If yes, please list dosage and frequency: _____

Are you currently taking any supplements, including vitamins, minerals, fish oil, protein powders, sports drinks, etc? __ Y __ N
If yes, please list type, amount and frequency: _____

Please list any medical conditions (such as asthma, cancer, diabetes, heart disease, Alzheimer's, arthritis, etc.) that an immediate family member had in the past or has currently. An immediate family member is a parent, sibling, grandparent or blood-related aunt/uncle: _____

Have you had any recent lab work? If yes, please provide type of tests and approximate dates:

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Gastrointestinal History

Do you have any gastrointestinal symptoms? ___ Y ___ N If yes, check any which apply.
___ Gas/bloating ___ Nausea/vomiting ___ Diarrhea ___ Constipation ___ Acid reflux
If you have symptoms, have you spoken with a gastroenterologist? ___ Y ___ N
Please describe any results of bloodwork or tests you have undergone for these symptoms.

Reproductive History (females only)

Do you still menstruate? ___ Y ___ N Are your periods regular? ___ Y ___ N
If no, please describe:
Do you use prescription birth control, such as pills, rings, intrauterine or transdermal devices?

Physical Activity History

Do you currently participate in physical activity/exercise? If yes, please complete the chart below. ___ Y ___ N
If no, are you limited in your ability to exercise by a physical condition, injury or doctor recommendation? ___ Y ___ N
If yes, please explain:

Do you currently have any exercise goals? ___ Y ___ N
If yes, please explain:

Activity	Type/Intensity (Low-Moderate-High)	# days/week	Duration (minutes)
Cardio (walk/bike/run/aerobics)			
Strength-training (weights, pilates, some yoga, resistance cords)			
Team/organized sports (basketball, soccer, ultimate Frisbee)			
Stretching/yoga			
Other (gardening, construction work)			

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Lifestyle History

On average, how many hours of sleep do you get per night? ____ Weeknights ___ Weekends
Do you drink alcohol? __ Y __ N
If yes, how many drinks per week and what type (beer, wine, liquor)? _____
Do you smoke? __ Currently __ In the past __ Never
If currently or in the past, how much per day? _____
Do you use recreational drugs? __ Currently __ In the past __ Never
If currently or in the past, what type and frequency? _____

Please rate these daily stressors as they apply to your life on a scale of 0 (not at all) to 5 (very high stress):

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

Diet History

Do you follow a special diet or have dietary restrictions (medical, religious, cultural)? __ Y __ N
If yes, please explain: _____

_____

_____

Please list any known or suspected food allergies, intolerances or sensitivities: _____

_____

_____

Have you every intentionally tried to lose/gain (circle) weight in the past? __ Y __ N
If yes, at what age and what diet/plan did you follow? _____

_____

_____

_____

Dietary Intake Patterns

On average, how many days per week do you eat the following meals:

____ Breakfast ____ Lunch ____ Dinner

Do you eat snacks? __ Y __ N
If yes, how often per day and what type? _____

_____

_____

How many meals per week are eaten (prepared) away from home and which ones (breakfast/lunch/dinner)? _____
How many days per week do you pack a lunch? _____
Who prepares the majority of meals eaten at home? _____
Who grocery shops for food and where? _____

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Please check all of the following characteristics that pertain to you on a regular basis:

___ Fast eater ___ Emotional eater (stressed, sad, bored, etc.) ___ Late-night eater
___ Distracted eater (watching TV, reading, driving, etc) ___ Eat when not hungry
___ Eat too much ___ Frequent traveler ___ Dislike planning meals/menus/food prep
___ Confused about nutrition ___ Dislike traditional "healthy" foods
___ Frequently eat pre-made or convenience foods for meals or snacks
___ Eat when anxious or eating certain foods causes anxiety

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Food Frequency Intake

Please indicate with what frequency you eat/drink the following:

Food/Beverage	Never	2-3x/month	1x/week	2-3x/week	1x/day	2-3x/day
Fruit (fresh, canned, dried, frozen)						
Vegetables (fresh, frozen, canned)						
Red meat, type:						
Pork, type:						
Poultry (chicken, turkey)						
Deli meat, type:						
Fish, type:						
Beans, type:						
Whole grains (pasta, bread, rice):						
Nuts/nut spreads:						
Soy products, type:						
Eggs/egg substitutes:						
Cookies, cakes, pastries						
Fried foods, type:						
Olive oil						
Vegetable oil						
Butter						
Margarine						
Yogurt, type:						
Cheese						
Milk, type:						
Coffee (indicate decaf or regular)						
Soda (indicate regular or diet)						
Juice						
Artificial sweeteners						
Frozen meals						
Fast food						
Restaurant meals						
Vending machine snacks						

Food likes: _____

_____

_____

Food cravings: _____

_____

_____

Food dislikes: _____

_____

_____

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