

New Patient Intake Form

All information received on this form will be treated as strictly confidential. Please fill out the form completely and accurately. This information is essential to helping me develop a nutrition plan that addresses your needs, goals, and interests that is also safe and effective.

Patient Name:	Gender: <input type="checkbox"/> M <input type="checkbox"/> F
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Date of Birth:	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Partnered <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed
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Social Security Number (required to bill insurance):

Mailing Address:

City:	State:	Zip:
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Home Phone:	Work Phone:	Cell Phone:
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Email:

How would you prefer to be contacted? Email Cell Work Home

If you chose to be contacted via phone, do you prefer calls or texts? Call Text

Occupation: Retired Out of Work/In Between Jobs

Primary Care Physician:

Referring Physician:

If not referred by a physician, how did you hear about me?

Insurance Information. If we are billing insurance, please bring your card(s) to your appointment. Not all insurance companies provide coverage for medication nutrition therapy or nutrition counseling. Please verify coverage with your provider. Note that patients are responsible for all non-covered charges, including co-pays, co-insurance, deductible, and/or non-covered services.

Primary Insurance Carrier:

Relationship to Insured: Self Spouse Child Other

Subscriber ID #: _____ Group #: _____

Secondary Insurance Carrier:

Relationship to Insured: Self Spouse Child Other

Subscriber ID #: _____ Group #: _____

Anthropometrics

Height:	Current Weight:	Desired Weight:
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Have you gained or lost weight in the last 6 months to a year? Yes No

Please explain:

Are you pregnant? Yes No Due Date:

What is the primary reason for your visit?

Readiness. On a scale of 1 (not willing) to 5 (very willing), please indicate your readiness/willingness to do the following:

<u>To improve your health, how ready/willing are you to...</u>	1	2	3	4	5
Make significant changes to the types of foods you eat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Engage in regular exercise/physical activity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Keep a food diary of everything you eat each day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Change the timing of the meals you eat during the day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Include regular healthy and structured snacks in your day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Medical History

Please indicate whether you or your relatives* have been diagnosed with any of the following diseases or conditions.

*Relatives include: parents, grandparents, and siblings

DISEASE/CONDITION	Self	Relative	DISEASE/CONDITION	Self	Relative
ADHD	<input type="checkbox"/>	<input type="checkbox"/>	High Triglycerides	<input type="checkbox"/>	<input type="checkbox"/>
Allergies (non-food)	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>
Alzheimer's/Dementia	<input type="checkbox"/>	<input type="checkbox"/>	Hypertension (High Blood Pressure)	<input type="checkbox"/>	<input type="checkbox"/>
Amputation	<input type="checkbox"/>	<input type="checkbox"/>	Hyperthyroidism	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Hypoglycemia (low blood sugar)	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Hypothyroidism	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Hysterectomy	<input type="checkbox"/>	<input type="checkbox"/>
Autoimmune condition	<input type="checkbox"/>	<input type="checkbox"/>	Intestinal Disease	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	Irritable Bowel Syndrome (IBS)	<input type="checkbox"/>	<input type="checkbox"/>
Autism Spectrum Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease/Failure	<input type="checkbox"/>	<input type="checkbox"/>
Bariatric Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/>
Bowel Resection	<input type="checkbox"/>	<input type="checkbox"/>	Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Metabolic Syndrome	<input type="checkbox"/>	<input type="checkbox"/>
Celiac Disease	<input type="checkbox"/>	<input type="checkbox"/>	Oral Pain	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Fatigue Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	Osteoarthritis	<input type="checkbox"/>	<input type="checkbox"/>
Cirrhosis	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	Pancreatitis	<input type="checkbox"/>	<input type="checkbox"/>
COPD	<input type="checkbox"/>	<input type="checkbox"/>	Parkinson's Disease	<input type="checkbox"/>	<input type="checkbox"/>
Crohn's Disease	<input type="checkbox"/>	<input type="checkbox"/>	Peptic Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	Phenylketonuria/PKU	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes, Type 1	<input type="checkbox"/>	<input type="checkbox"/>	Polycystic Ovarian Syndrome (PCOS)	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes, Type 2	<input type="checkbox"/>	<input type="checkbox"/>	Prostate Problems	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes, Gestational	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric conditions	<input type="checkbox"/>	<input type="checkbox"/>
Prediabetes	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell Disease	<input type="checkbox"/>	<input type="checkbox"/>
Diverticulosis/Diverticulitis	<input type="checkbox"/>	<input type="checkbox"/>	Sinusitis	<input type="checkbox"/>	<input type="checkbox"/>
Eating Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Sleep Apnea	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy or seizures	<input type="checkbox"/>	<input type="checkbox"/>	Substance Abuse	<input type="checkbox"/>	<input type="checkbox"/>
Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>	Swallowing/Chewing Difficult	<input type="checkbox"/>	<input type="checkbox"/>
Food Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Ulcerative Colitis	<input type="checkbox"/>	<input type="checkbox"/>
Food Sensitivities/Intolerances	<input type="checkbox"/>	<input type="checkbox"/>	Urinary Tract Conditions	<input type="checkbox"/>	<input type="checkbox"/>
Gallbladder Disease/Gallstones	<input type="checkbox"/>	<input type="checkbox"/>	Other Disease/Condition (please specify):		
Gallbladder Removal	<input type="checkbox"/>	<input type="checkbox"/>			
Gout	<input type="checkbox"/>	<input type="checkbox"/>			
Heart Attack/Angina	<input type="checkbox"/>	<input type="checkbox"/>			
Heartburn	<input type="checkbox"/>	<input type="checkbox"/>			
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>			
Heart Failure	<input type="checkbox"/>	<input type="checkbox"/>			
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>			
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>			

Lifestyle

Do you have children? Yes No Ages: _____

Who do you live with? _____

Which meals do you eat regularly? Breakfast Lunch Dinner Snacks

Who prepares the majority of your meals? _____

Who does the grocery shopping? _____

Where do you grocery shop, and how often? _____

How much time do you spend cooking/preparing meals each day? _____ Hours/Minutes

How often do you eat out/take-out each week? Rarely 1-2 times 3-4 times 5-6 times 7+ times

What restaurants? _____

Do you find cooking difficult? Yes No Describe: _____

How often do you exercise? None Light (1-2x/wk) Moderate (2-3x/wk) Active (>4x/wk)

Please describe exercise activity and duration: _____

Does anything limit you from being physically active? _____

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

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

Do you drink alcohol? Never In the past Currently How long? _____

Type/Amount/Frequency? _____

Drug use? Never In the past Currently How long? _____

Type/Amount/Frequency? _____

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

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

What helps you to unwind? _____

Eating Style. Based on how you eat on a regular basis, please check all that apply:

Inconsistent meal pattern/timing	<input type="checkbox"/>	Snack late at night	<input type="checkbox"/>
Skip meals	<input type="checkbox"/>	Eat standing up	<input type="checkbox"/>
Eat very fast	<input type="checkbox"/>	Eat in the car	<input type="checkbox"/>
Eat until you are uncomfortably full	<input type="checkbox"/>	Eat while watching TV	<input type="checkbox"/>
Binge or eat without being able to stop	<input type="checkbox"/>	Eat while reading or on the computer	<input type="checkbox"/>
Use food as a reward	<input type="checkbox"/>	Eat with others	<input type="checkbox"/>
Have specific cravings	<input type="checkbox"/>	Eat when bored	<input type="checkbox"/>
Eat when stressed	<input type="checkbox"/>	Eat when you are hungry	<input type="checkbox"/>
Eat when you are anxious	<input type="checkbox"/>	Eat when you are not hungry	<input type="checkbox"/>

Do you follow any special diet or have diet restrictions or limitations for any reason (health, cultural, religious, or other)? Please explain:

Have you ever been advised by your physician to follow a special diet? Yes No

What type? _____ Are you currently following that diet? Yes No

Do you read food labels? Yes No

What do you look at on the label?

Do the nutrition facts influence your decision to eat the food? Yes No

Do you avoid certain foods or food groups? Yes No

What do you avoid?

Please list any food allergies, sensitivities, or intolerances: