Patient Information

Date: ____________________

Name: ______________________________ DOB: ____________________

Address: ____

____

Telephone: Home: ____________________ Work: ____________________ Ext ________

Cell: ____________________ Fax: ____________________

Email: ____________________ Occupation: ____________________

Primary Health Concern: ____

Other Health Concerns: ____

Referral Source: ____________________ Primary Care Physician: ____________________

Other Healthcare Professionals involved in your care: ______________________________

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What types of therapies have you tried for your health concern(s) or to improve your overall health?

o diet modification o acupuncture o chiropractic o herbs
o vitamins/minerals o homeopathy o conventional drugs o fasting

o Other ____

Previous nutrition counseling? __________ With Whom? ____________________

Following a special diet? ____

Lactose intolerant? ____________________ If so, do you avoid all dairy products? __________

Food intolerances/allergies and reactions: ______________________________

Stumbling blocks in reaching your goals?: ______________________________

Current exercise routine: ____

Activity limitations? (pain, injuries, etc.) ______________________________

Stress level (1-10 scale): ______ Cause(s): ____

How do you relax/de-stress?: ____

Average # hours sleep/night: ______ Any trouble sleeping?: ____________________ Low libido? __________

Smoker? (#/day): ____________ Alcohol Drinks/wk: _______________ Caffeine cups/day: ________________

Do you experience any of these general symptoms?

o Headaches	o Insomnia	o Debilitating fatigue	o Forgetfulness
o Depression	o Anxiety attacks	o Constipation	o Diarrhea
o Chronic Pain	o Itching/Rash	o Nausea/Vomiting	o Shortness of Breath

Have you and/or family members experienced:

	Self	Family		Self	Family
High blood pressure:	o	o	Anemia/Fatigue:	o	o
Diabetes:	o	o	Depression:	o	o
High cholesterol:	o	o	Anxiety/Nervousness:	o	o
Ulcers:	o	o	Constipation/Diarrhea:	o	o
Overweight or Obesity:	o	o	Reflux/Heartburn:	o	o
Insomnia:	o	o	Heart Attack/Stroke:	o	o
Alzheimer's Disease:	o	o	Cancer:	o	o
Hyper/Hypo Thyroid:	o	o	Type: _______________________ Who?: _______________		

Other: ____

Major Hospitalizations, Surgeries, Injuries:

Year	Surgery, Illness, Injury	Outcome

Have you unintentionally gained or lost 10 pounds or more in the past 3 months? ______________________

Do you consider yourself: o Obese o Overweight o Normal Wt o Underweight Weight today: ______

What are your current health goals? ____

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