



# Health & Diet History

### Personal Information

Name: \_\_\_\_\_ Date of Birth: \_\_/\_\_/\_\_\_\_ Age: \_\_\_\_ Today's Date: \_\_/\_\_/\_\_\_\_  
 Gender:  M  F Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_  
 How were you referred to us?  Website  Friend  Physician  Advertisement  Other  
 What is the reason for your visit? \_\_\_\_\_  
 Have you ever worked with a registered dietitian in the past?  Y  N  
 Email address: \_\_\_\_\_ Phone (home): \_\_\_\_\_ Phone (mobile): \_\_\_\_\_  
 Home Address: \_\_\_\_\_ Apt #: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_ Zip: \_\_\_\_\_  
 Emergency Contact Name & Phone: \_\_\_\_\_  
 Please list anyone you wish to give full access to your personal health information (spouse, parent, children, and grandchildren):  
 (include phone numbers) \_\_\_\_\_  
 Do you have difficulty reading?  Y  N  
 How would you like us to contact you? (check all that apply)  
 Home Address  Home Phone  Mobile Phone  Email  Other: \_\_\_\_\_ May we leave a message?  Y  N

### Physician Information

Primary Physician's Name: \_\_\_\_\_ Specialty: \_\_\_\_\_  
 Office Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_ Zip: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Website: \_\_\_\_\_  
 Did your physician refer you to a dietitian?  Y  N May we contact this physician with updates on your progress?  Y  N  
 Secondary Physician's Name: \_\_\_\_\_ Specialty: \_\_\_\_\_  
 Office Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_ Zip: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Website: \_\_\_\_\_  
 Were you referred by your physician  Y  N  
 May we contact the above physician(s) to obtain medical information and to provide updates on your progress?  Y  N

### Billing Information

Are you eligible to receive Medicare benefits?  Y  N

### Medicare Waiver

I understand that Medicare will only pay for nutritional services when there is a diagnosis of diabetes or pre-dialysis renal disease. I understand that I will be responsible for any fees associated with services rendered for any other medical conditions.

\_\_\_\_\_  
 Client or Representative Signature Date

Name of Primary Insurer: \_\_\_\_\_  
 Address of Insurer: \_\_\_\_\_ Date Effective: \_\_\_\_\_  
 Primary Insured's Name: \_\_\_\_\_ Relationship to Client: \_\_\_\_\_  
 Policy Holder's DOB: \_\_/\_\_/\_\_\_\_ Policy Holder's SSN# (optional): \_\_-\_\_-\_\_\_\_  
 Group #/Code: \_\_\_\_\_ Policy # or ID: \_\_\_\_\_  
 Copay \$: \_\_\_\_\_  
 Name of Secondary Insurer: \_\_\_\_\_  
 Address of Insurer: \_\_\_\_\_  
 Primary Insured's Name: \_\_\_\_\_ Relationship to Client: \_\_\_\_\_  
 Policy Holder's DOB: \_\_/\_\_/\_\_\_\_ Policy Holder's SSN# (optional): \_\_-\_\_-\_\_\_\_  
 Group #/Code: \_\_\_\_\_ Policy # or ID: \_\_\_\_\_  
 Copay \$: \_\_\_\_\_

**Medical History** Diagnoses/Medical Conditions (check all that apply):

- Depression     Acid Reflux     Digestive Disorders     Osteoporosis     Liver Disease     Kidney Disease
  - Anemia     Gallstones     Gestational Diabetes     Nausea     Vomiting     Alteration in taste
  - Constipation     Hypertension     High Cholesterol     Fatigue     Feeding Tube     High Triglycerides
  - Gout     Heart Disease     Celiac Disease     Skin Problems     Chronic Pain     Congestive Heart Failure
  - Parkinson's     PCOS     Multiple Sclerosis     Diarrhea     Colitis     Diverticulosis/Diverticulitis
  - Anorexia     Bulimia     Disordered Eating     Binge Eating     Diabetes     Metabolic Syndrome
  - Gillian Barre     IBS     Thyroid Disease     Stomach Ulcers     Mental Illness     Mental Retardation
  - Drug Addiction     Alcoholism     Autoimmune Disease     Seizures     Asthma     Non-Healing Wounds
  - Chronic UTI's     Kidney Stones     Unplanned Weight Gain     Glaucoma     Goiter     Unplanned Weight Loss
  - Obesity     Glaucoma     Macular Degeneration     HIV     AIDS     Hair Loss
  - Colostomy     Excessive Thirst     Excessive Hunger     GI Bleeding     Malnutrition     Bleeding Gums
- Cancer (list type): \_\_\_\_\_
- Radiation: (list dates of treatment): \_\_\_\_\_
- Chemotherapy (list dates of treatment): \_\_\_\_\_

**Women Only** (check all that apply):

- Trying to become pregnant     Pregnant (how many months \_\_\_ )     Breastfeeding
- Menstrual Irregularities     Endometriosis Fibroids/Ovarian Cysts     PMS
- Breast Cancer     Menopause (age: \_\_\_ )     Infertility
- Chronic Yeast Infections     Ovarian Cancer

**Men Only** (check all that apply):

- BPH     Prostate Cancer     Testicular Cancer

**List all Prescription Medications:**

---



---

**Known Lab Values:** Sodium \_\_\_ Potassium \_\_\_ Glucose \_\_\_ A1c \_\_\_ TSH \_\_\_ Cholesterol \_\_\_ Triglycerides \_\_\_  
 Prealbumin \_\_\_ Albumin \_\_\_ Hemoglobin \_\_\_ Hematocrit \_\_\_ BUN \_\_\_ Creat \_\_\_  
 Other: \_\_\_\_\_

**Health History**

- Do you use artificial sweeteners?  Aspartame  Saccharin  Splenda \_\_\_ times per  Day  Week  Month
- Do you use caffeine?  Coffee  Tea  Carbonated Beverages \_\_\_ times per  Day  Week  Month
- Do you use tobacco?  Cigarettes  Cigars  Smokeless Tobacco \_\_\_ # per  Day  Week  Month
- If you quit smoking, for how long did you smoke? \_\_\_  Years Date of last tobacco product: \_\_\_\_\_
- Do you use alcohol?  Beer  Wine  Liquor \_\_\_ drinks per  Day  Week  Month
- Do you have difficulty chewing?  Y  N Do you have difficulty swallowing?  Y  N Do you have mouth pain?  Y  N
- Do you wear dentures?  Y  N  Uppers  Lower  Partials Do they fit well?  Y  N

**Weight History**

Height: \_\_\_ ft \_\_\_ inches

Weight (pounds) \_\_\_\_\_

Do you feel your weight is:  Too High  Too Low  Healthy  Not Sure

Weight 6 months ago: \_\_\_ Highest weight since age 18: \_\_\_ Lowest weight since age 18: \_\_\_

Current weight trend:  Gaining  Losing  Intentionally  Unintentionally

Is your goal to:  Lose Weight  Gain Weight  Maintain Weight

Personal Goal Weight: \_\_\_\_\_

How soon do you expect to reach your goal? \_\_\_ Years \_\_\_ Months \_\_\_ Weeks \_\_\_ Days

### Diet History

Have you ever felt your eating was out of control?  Y  N

Do you have trouble keeping food down?  Y  N

Have you ever been treated for disordered eating?  Y  N

Are you working with a therapist?  Y  N Have you ever worked with a therapist?  Y  N

If yes, please list the therapist's name: \_\_\_\_\_

Do you skip meals?  Breakfast  Lunch  Dinner

What types of foods do you typically eat?  Made from scratch  Fast Food  Convenience  Restaurants

How often do you eat out? \_\_\_\_ times per day \_\_\_\_ times per week \_\_\_\_ times per month

What methods have you tried in the past to reach your personal goals?  Fasting  Low-Carb Diets  Low-Calorie Diets  Low-Fat Diets  Meal Replacements  Bariatric Surgery  Herbs  Chiropractic  Acupuncture  Weight Loss Pills  Exercise  Hypnosis  Colonics  Low Glycemic Index Diets  Weight Watchers  The Zone Diet  Other: \_\_\_\_\_

What supplements are you currently using?:  Multivitamin  Vitamin C  Vitamin E  Vitamin D  Acidophilus  Digestive Enzymes  Omega-3 (fish oils)  CoQ10  Protein Powders  Flax List all other nutritional supplements/products: \_\_\_\_\_

Current Diet Restrictions:  Salt  Vegetarian  Carbohydrates  Fat  Protein  Gluten  Nuts, Seeds, Hulls  Other: \_\_\_\_\_

Food Allergies/Intolerances: \_\_\_\_\_

Religious/Cultural Food Preferences: \_\_\_\_\_

How many servings do you consume daily?

Fruit  1  2  3  4  5 or more

Vegetables  1  2  3  4  5 or more

Dairy  1  2  3 or more

Meat (ounces)  1  2  3  4  5  6

Poultry (ounces)  1  2  3  4  5  6

Fish (ounces)  1  2  3  4  5  6

Nuts & Seeds  1  2  3 or more

Beans  1  2  3 or more

Whole Grains  1  2  3  4  5  6  7  8  9  10  11  12 or more

### Exercise History

Has your physician restricted you from doing any physical activity?  Y  N If yes, what restrictions? \_\_\_\_\_

Do you experience any of the following during exercise:  Shortness of Breath  Irregular Heartbeat  Lightheadedness

Leg Cramps  Stomach Cramps  Chest Pain  Nausea  Back Pain  Joint Pain

How often do you exercise? \_\_\_\_ minutes per day \_\_\_\_ days per week

Types of activities (check all that apply):  Strength Training (weights)  Cardio  Aerobics  Pilates  Yoga  Nia

Running  Walking  Swimming  Cycling  Competitive Sports  Tennis  Golf  Hiking  Skiing  Other: \_\_\_\_\_

How would you classify your activity:

Sedentary (little or no activity)

Light (light activity 1-3 days per week)

Moderate (active for ~30 minutes 3-5 days per week)

Heavy (vigorous activity > 30 minutes 6-7 days per week)

Is there anything you would like to add?