



Date _____

*Welcome to Nutrition Clinic.
Please take a few moments to fill in your information.*

Name _____

Street Address _____

City _____ State _____ Zip _____

Home Phone () _____ Other Phone () _____

E-Mail Address _____ Date of Birth ____ / ____ / ____

Height _____ Weight _____ Blood Type (if known) _____

Job Profession _____

Do you have children? _____ If so, how many? _____ Age(s) _____

How did you hear about Nutrition Clinic?

Who is your Primary Care Physician? _____

For women, who is your OB/GYN? _____

Are you seeing any other Health Care Provider? _____ If so, whom? _____

In an emergency, whom do we contact? Name _____

Phone number(s) _____

Do you use or have you ever used (check all that apply):

_____ Alcohol—How many glasses per week is usual? _____

_____ Cigarettes—Number of packs per day _____

Within the last year have you taken any prescription medications? Yes _____ No _____

If yes, list below all prescriptions and conditions for which you are (or were) taking them:

Are you taking any over-the-counter medications on a regular basis? Yes _____ No _____

If yes, please list below all of them and the reason:

Are you taking any vitamins or supplements? Yes____ No____ If yes, please list below and include amounts:

Do you follow a particular food diet or have any special dietary habits?
Yes____ No____ If yes, please specify below:

Have you gained or lost more than 20 lbs in the last year? Yes____ No____

Please list the forms and frequency of regular exercise (ex: swimming, cycling, running) and age you began:

Exercise	Hrs/Week	Age
_____	_____	_____
_____	_____	_____

Have you ever had any surgery? Yes____ No____ If yes, please list and indicate date below:

Type of surgery	Date
_____	_____
_____	_____

Do you have or have you ever had (check all that apply):

- | | |
|---|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Herpes Simplex, Fever Blisters, Cold Sores |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Cancer (specify) _____ | <input type="checkbox"/> Hysterectomy (Ovaries Removed? ___Yes ___No) |
| <input type="checkbox"/> Chronic Bronchitis | <input type="checkbox"/> Kidney Infection |
| <input type="checkbox"/> Chronic Headaches | <input type="checkbox"/> Liver Problems |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> Loss of Balance |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Neurological Problems |
| <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Parasitic Infection |
| <input type="checkbox"/> Ovarian Cysts | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Gall Bladder Problems | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Any Allergies: List: | <input type="checkbox"/> Ulcers |

Have you ever been treated for cancer? Yes____ No____ If yes, explain therapy:

Please use this space for any other pertinent information you want to include to assist Nutrition Clinic to most effectively help you reach your health goals:
