



116 Holloway Rd., Ste B  
Ballwin, MO 63011  
**636-386-3333**

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

Name \_\_\_\_\_ Date: \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_ E-mail address: \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Blood Type (if known) \_\_\_\_\_

Home Phone # (        ) \_\_\_\_\_ Other Phone # (        ) \_\_\_\_\_

Job Profession: \_\_\_\_\_

Do you have children? \_\_\_\_\_ If so, how many? \_\_\_\_\_ Ages? \_\_\_\_\_

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:

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Do you follow a particular food diet or have any special dietary habits?  
Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please specify below:

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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 _____
_____	_____	_____
_____	_____	_____

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                                       |

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Have you ever been treated for cancer? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, explain therapy:

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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:

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