Nutrition Therapy - New Client 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 the nutrition therapist to develop a wellness program that addresses your needs, goals and interests and is safe and effective.

Demographics						
First Name		Middle Name			Last Name	
Date of Birth		Age		Gender	☐ Male ☐ Female	
Mailing Address						
City, State, Zip code						
Preferred phone				☐ Home ☐ Work ☐ Mobile		
Secondary phone				☐ Home ☐ Work ☐ Mobile		
Email address						
Referred by						

Concerns
What health and/or nutrition concerns would you like to focus on during your visit?
1.
2.
3.

Medical History

Please check "yes" for the health conditions that your doctor has diagnosed, and then record the approximate date of onset.

CONDITION	Yes	Date of Onset	CONDITION	Yes	Date of Onset
GASTROINTESTINAL			**INFLAMMATORY / AUTOIMMUNE**		
Irritable Bowel Syndrome	☐		Chronic Fatigue Syndrome	☐	
Inflammatory Bowel Disease	☐		Rheumatoid Arthritis	☐	
Crohn's Disease	☐		Lupus SLE	☐	
Ulcerative Colitis	☐		Frequent Infections	☐	
Celiac Disease	☐		Severe Infectious Disease	☐	
Gastric or Peptic Ulcer Disease	☐		Herpes	☐	
GERD, reflux / heartburn	☐		Gout	☐	
Hepatitis C or Liver Disease	☐		Other:	☐	
Food Intolerance	☐				
Other:	☐				
RESPIRATORY			**MUSCULOSKELETAL / PAIN**		
Asthma	☐		Osteoarthritis	☐	
Chronic Sinusitis	☐		Chronic pain	☐	
Sleep Apnea	☐		Fibromyalgia	☐	
Bronchitis or Emphysema	☐		Migraines	☐	
Tuberculosis	☐		Other:	☐	
Other:	☐				
CARDIOVASCULAR			**URINARY / REPRODUCTIVE**		
Heart Disease / Heart Attack	☐		Kidney Stones	☐	
Stroke	☐		Urinary Tract Infections	☐	
Elevated Cholesterol	☐		Yeast Infection	☐	
Irregular Heart Rate	☐		Prostate Problem	☐	
High Blood Pressure	☐		Other:	☐	
Other:	☐				
NEUROLOGICAL / BRAIN			**METABOLIC / ENDOCRINE**		
Depression	☐		Type 1 Diabetes	☐	
Anxiety	☐		Type 2 Diabetes	☐	
Bipolar disorder	☐		Metabolic syndrome	☐	
ADD/ADHD	☐		Hypoglycemia	☐	
Multiple Sclerosis	☐		Hypothyroidism	☐	
Seizures	☐		Hyperthyroidism	☐	
Anorexia Nervosa	☐		Polycystic Ovarian Syndrome	☐	
Bulimia	☐		Infertility	☐	
Unspecified Eating Disorder	☐		Other:	☐	
Parkinson's Disease	☐				
Other:	☐				
DERMATOLOGICAL			**CANCER: Please list type(s) and treatments.**		
Eczema	☐				
Psoriasis	☐				
Acne	☐				
Other:	☐				

Additional health conditions your doctor has diagnosed:

Please list any previous injuries, surgeries, and hospitalizations. Provide your age and date if known.

Family History

Have any of your close relatives (parent, sibling, child grandparent) been diagnosed with the following? Please check, describe, and provide age of onset for those that apply.

Condition	Yes	Family Member(s)	Age of Onset	Description
Heart Disease	☐			
High Blood Pressure	☐			
Stroke	☐			
Diabetes	☐			
Cancer	☐			
Overweight	☐			
Food Intolerance	☐			
Autoimmune Disease	☐			

Oral History

Do you visit a dentist twice per year? ☐ Yes ☐ No

Allergies		Allergic Symptoms Experienced
Food		
Medication		
Supplement		
Environmental		

Medications and Supplements: Please list all prescription medications, nutritional supplements, and herbs/botanicals you are currently taking.

Medication Name	Year Started	Dose	Frequency	Reason
Herb/Supplement	**Year Started**	**Dose**	**Frequency**	**Reason**

Have you had prolonged or regular use of NSAIDS (Advil, Aleve, etc.), Motrin, Aspirin? ☐ Yes ☐ No

Have you had prolonged or regular use of Tylenol? ☐ Yes ☐ No

Have you had prolonged or regular use of acid-blocking drugs (Zantac, Pepcid, etc.)? ☐ Yes ☐ No

Have you taken antibiotics > 3 times per year? ☐ Yes ☐ No

Have you been on antibiotics long term (> 1 month continuously)? ☐ Yes ☐ No