Nutrition Works

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Initial Client Consult Form

First Name	Last Name	Middle Name	Date of Birth		Today's Date
Street Address		City	State	Zip	Gender
Phone	Alternate Phone	E-mail Address	Height		Weight

Health History

Chief Complaints (and how long you have had them):

Current Diagnoses:

Treatment History (What have you tried, and how well did it work – Use separate page if needed):

Any testing for celiac disease? Results?
Do you have a history of diagnosed or suspected Eating Disorders? (Anorexia Nervosa or Bulimia)
Do you have a history of/suspected addictions? (Food, drug, alcohol, behavioral):

What medications (prescription or over-the-counter) do you currently take?

What supplements do you currently take?

Do you have allergies of any kind (in other words, cat, dust, pollen, food, meds, etc.)? Please list:	Are there any foods that "don't agree" with you?

Eating Habits/Lifestyle Considerations

What is your occupation?	How often do you cook from scratch?	How often do you eat out?

Do you tend to skip meals?	Do you ever eat for comfort?	What situation(s) cause you to eat for comfort?

How do your health problems interfere with your life?	What foods (if any) do you crave?	Are there any foods you could not give up for 2 weeks?

On a scale from 1-10, how badly are these problems affecting your life?

On a scale from 1-10, how committed are you to getting better?

Do you have "support" from family/friends? Who?

What are your main health concerns/treatment goals?

Office Use Only- Notes