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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 |
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