CLIENT INFORMATION

Name _____

DOB ___ /___ /_____Cell Phone_____

Occupation_____

Address_____

City_____ State_____ Zip_____

E-mail _____

Referred By_____

Nutrition by Bethany

13955 W. Preserve Blvd., Ste. 200 Burnsville, MN 55337
Phone: (952) 890-0804 Fax (952) 890-1095

MEDICAL HISTORY:

Primary Care Provider: _____ Phone Number _____

Current Height: _____ Current Weight: _____

Current Medications:_____

_____

_____

Please list all medical conditions: _____

_____

_____

□ Yes □ No Do you drink alcohol? Number per week: _____

□ Yes □ No Do you smoke cigarettes? Amount per day: _____ How long? _____

□ Yes □ Are you currently taking any food or nutritional/herbal supplements? If yes, explain: _____

_____

Do you or anyone in your family have a history of the following conditions? Please indicate which, and explain:

□ Yes □ No Asthma
□ Yes □ No Cancer
□ Yes □ No Cardiovascular Disease
□ Yes □ No Diabetes
□ Yes □ No Drug Dependency
□ Yes □ No Eating Disorder
□ Yes □ No Food Allergies
□ Yes □ No Food Intolerances
□ Yes □ No Kidney Disease
□ Yes □ No High Cholesterol
□ Yes □ No High Blood Pressure
□ Yes □ No Intestinal Problems
□ Yes □ No Menstrual Problems
□ Yes □ No Osteoporosis

Other/Explain: _____

_____

Are you currently being treated for any medical conditions? □ Yes □ No Explain: _____

_____

WEIGHT/DIETING HISTORY:

Do you consider yourself: □ Underweight □ Overweight □ Obese □ Just Right

Have you ever been advised by your physician to follow a special diet? □ Yes □ No Explain: _____

_____

Have you tried to lose weight before? □ Yes □ No Explain: _____

_____

Have you ever been diagnosed with an eating disorder? □ Yes □ No Explain: _____

_____

Do you currently exercise for weight control? □ Yes □ No Explain: _____

EATING HABITS:

How many days per week do you eat: Breakfast? _____ Lunch? _____ Dinner? _____

Do you snack? □ Yes □ No Explain: _____

Do you buy or pack your lunches? Pack: _____ Buy: _____

Do you eat out? □ Yes □ No How many meals per week? _____

Who usually prepares the food at home? _____

Who does the grocery shopping? _____

Please specify how many of the following beverages you consume each week:

Alcohol: _____	Regular Soft Drinks: _____	Herbal Tea: _____
Caffeinated Coffee: _____	Diet Soft Drinks: _____	Regular Tea: _____
Decaf Coffee: _____	Fruit Juice: _____	Sports Drinks: _____
Diet/Supplement drinks: _____	Green Tea: _____	Water: _____

Other Beverages: _____

What foods do you crave? _____

What foods do you avoid? Explain: _____

_____

_____

SLEEP AND STRESS HABITS:

Do you have good energy levels? □ Yes □ No □ Inconsistent Does napping help? □ Yes □ No

Can you attribute low energy to anything in particular? □ Yes □ No Explain: _____

What time do you normally go to bed? _____ Fall asleep? _____ Awaken for the day? _____

How many hours do you need to feel rested? _____ How many do you get? _____

On a scale of 1 to 10, what is your stress level most days? (1=minimal, 10=extreme)? _____

Life Stressors: □ Work/School □ Finances □ Health □ Relationships □ Other

GOALS AND EXPECTATIONS:

What are your main health concerns? _____

_____

_____

What do you think would make the most difference in your overall health? _____

_____

_____

_____

_____

Please write a brief summary of any information that will be helpful to me regarding your health history. In your own words, tell me your story. _____

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