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| Name: | Email:  Phone Number: |

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| Health History |
| What are your main Nutrition & Health Goals?  Diagnoses:  Chief Complaints: 1. How long have you had them? 2. How much do they interfere with your life?  What have you tried, and how well did it work? |
| **Treatment History**  Lab testing for celiac disease? Results?  Is your gallbladder removed?  Do you have a history of diagnosed or suspected eating disorders? (Anorexia Nervosa, Bulimia)  Do you have a history of/suspected addiction? (Food, Drug, Alcohol, Behavioral)  Any body implants? Year? (Breast augmentation, Prosthetics, Pins, Screws, Pacemaker)  Do you have allergies? (Food, Medication, Dog, Cat, Dust, Pollen) |
| What medications do you currently take? (Prescription or Over the Counter) |
| What supplements do you currently take? (Vitamins/Minerals/Oils/Herbs) |

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| 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? |
| List Foods that don’t agree with you. | | What foods (if any) do you crave? | Are there any foods/drinks you could not give up for 2 weeks? | |
| Usual Beverages: | | | | |
| Usual Breakfast: | | | | |
| Usual Lunch: | | | | |
| Usual Dinner: | | | | |
| Usual Snacks: | | | | |
| How do your health problems interfere with your life?  On a scale from 1-10:  1. How badly are these problems affecting your life?  2. How committed are you to getting better?  3. Are you willing to keep a daily Food and Symptom Diary? | | | | |