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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?  |