Adult Medical Nutrition Therapy Form

Please take the time to answer each question carefully. This provides valuable information on your individual situation to allow for an most effective assessment. All questions are pertinent to the goal of designing a therapeutic nutrition care plan to best suit your unique needs.

General Information

Name:_____ Address: _____

Age: _____ Date of birth:_____ _____

Phone: _____ _____

Marital Status: □Single □Single, living with Significant Other □Married □Divorced □Widowed

Number of people in household and ages: _____

Who prepares meals? _____ Average hours of sleep per night: _____

Who is your primary care physician? _____

Habits

Alcohol – average drinks per day:
Beer _____
Wine _____
Hard liquor _____

Smoking – average smoked daily:
Cigarettes _____
Cigars _____
Pipe _____
Other _____

Exercise

Kind: _____

How often?_____ How long each session? _____

Recreational activities and hobbies: _____

_____

Health Assessment

Current Height _____ Current Weight _____

Have you recently lost □ or gained □ weight? □Yes □No

Was the weight loss or gain intentional? □Yes □No

What is your desirable weight range? _____

When did you last weigh within your desirable weight range?_____

Women only – Are you pregnant? _____ Nursing? _____

How is your dental health? _____ Do your gums bleed? _____

Do you taste food well? _____

Please list all medications that you currently take:

Prescription: _____

_____

Non-prescription: _____

Vitamins: _____

Herbal or other supplements: _____

_____

Please indicate whether you or a family member have/had any of the following conditions:

Condition	***Self***	***Family Member***	***Relationship to you:***
Diabetes	☐	☐	_____
Liver disease	☐	☐	_____
Cancer	☐	☐	_____
Orthopedic disorder	☐	☐	_____
Heart Disease	☐	☐	_____
High cholesterol	☐	☐	_____
High blood pressure	☐	☐	_____
Kidney disease	☐	☐	_____
Stomach/intestinal disorder	☐	☐	_____
Polycystic ovarian syndrome	☐	☐	_____
Depression	☐	☐	_____
Chronic stress or anxiety	☐	☐	_____
Osteoporosis	☐	☐	_____
Food Allergies	☐	☐	_____
Food Intolerances	☐	☐	_____
Headaches	☐	☐	_____
Asthma	☐	☐	_____
Other	☐	☐	_____

Have you noticed any of the following:

Brittle hair/nails _____ Fatigue _____

Eczema _____ Irregular menses _____

Ridges on fingernails _____ Intolerance to cold _____

Hypoglycemia _____ Insomnia _____

Do you experience any of the following? If yes, how often:

Heartburn _____ Belching _____

Nausea _____ Bloating _____

Vomiting _____ Gas/Flatulence _____

Diarrhea _____ Constipation _____

Diet History

How is your appetite? Good _____ Fair _____ Poor _____

Any change in appetite recently? _____

If yes, in what way? _____

What are your favorite foods? _____

Are you a vegetarian? If yes, specify type _____

Any food allergies or intolerances? _____

What foods do you dislike? _____

Have you ever been on a special diet for any reason? □Yes □No

If yes, please explain_____

Have you ever severely restricted your eating or caused yourself to vomit after eating?

□Yes □No

Do you ever skip meals? □Yes □No

Do you feel in control of your eating? □Yes □No

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

Do you have enough time to prepare decent meals? □Yes □No

Are any members of your family overweight or underweight? □Yes □No

What do you do to refresh/renew yourself? _____

What would you like to gain from this nutrition consult?

_____

_____

_____

Insurance Information

Name of Insurance Company:_____

Who is the primary insured person?_____

Cancellation policy: We will gladly reschedule or cancel appointments with24 hours notice without penalty. Appointments cancelled or missed without receipt of 24 hours advance notice will result in a cancellation charge of $35.00 This charge is not covered by insurance and is the client's sole responsibility.