Health Profile

Personal Information

First Name: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Cell: _____Email: _____

Birthdate: _____ Place of Birth: _____ Age: _____

Height: _____ Current weight: _____

Weight 6 months ago: _____

(To be completed by nutritionist)
BMI =

Weight 1 year ago: _____ Min. Adult Weight & at what age: _____

Maximum Weight & at what age: _____

Are you concerned about your weight or body shape/size? YES NO

If so, when did your weight/body concerns begin? _____

_____

Have you tried to lose (or gain) weight before? YES NO

If yes, which methods have you tried & did they work for you? _____

_____

_____

What are your specific nutrition concerns and goal(s) for this nutrition consultation? ___

_____

_____

_____

Social Information

Relationship Status: _____ Children? And their ages: _____

Pets: _____ Occupation: _____ Hours of work per week: _____

Health Information

Do you have any of the following conditions?
(In the space provided explain if anyone in your family has these conditions)

High blood pressure YES NO _____
High blood cholesterol YES NO _____
Heart attack and/or stroke YES NO _____
Cancer YES NO _____
Obesity/Overweight YES NO _____
Diabetes YES NO _____
Thyroid problems YES NO _____
Alcohol and/or drug abuse YES NO _____
Eating disorder YES NO _____
Depression/Mood problems YES NO _____
Gastrointestinal problems YES NO _____
Please circle type(s): acid reflux, gas, heartburn, irritable bowel syndrome, diarrhea, constipation, Crohn's disease, diverticulosis, celiac disease, other:
_____
Osteoporosis YES NO _____
Other: _____

Any other serious illnesses/hospitalizations/injuries? _____
_____

Any pain, stiffness, or swelling? _____

Are you currently taking any medications, including birth control and over-the counter drugs (such as aspirin, antacids, diet pills, laxatives, etc.)? YES NO
If yes, please list: _____
_____

Are you currently taking supplemental vitamin, herbs, or other dietary supplements?
YES NO
If yes, please list: _____
_____
Do you have any food allergies or food intolerances? YES NO
If yes, please list: _____

The following questions in this section apply to females only:
Check off the situations that apply to you currently:

- ☐ Irregular Periods
- ☐ Painful Periods
- ☐ Heavy Periods
- ☐ Menopause

Please indicate the date of your last menstrual cycle: _____

Are you pregnant? YES NO Are you breastfeeding? YES NO

Lifestyle Profile

How stressful do you consider your life right now?

1 2 3 4 5

Not stressful at all..... Extremely stressful

What are your primary sources of stress? _____

How is your food intake/tolerance affected by stress? *Please circle all that apply.*

No effect Eat more Eat less Eat different types of foods Irritable bowel

Do you currently exercise? YES NO

If yes, what do you do? _____

How many days per week? _____

How long per workout session? _____

Do you drink alcohol? YES NO

If yes, what, how much, and how often? _____

Do you use tobacco, marijuana, or other drugs? YES NO

If yes, what, how much, and how often? _____

How many hours of sleep do you typically get each day/night? _____

Do you have any sleep concerns? (*i.e.* difficulty falling and/or staying asleep, Sleep walking/eating, etc.) YES NO
If yes, please describe: _____

Typical Eating Pattern:

Are you following a special diet or eating plan at this time (i.e. vegetarian, Weight Watchers, etc.)? Yes No If yes, please describe: _____

_____

Are there any foods that you avoid? _____

_____

Please list your typical daily food/beverage intake below. NOTE: If you have two distinctive patterns (i.e. “good days” and “bad days”), please describe each pattern separately.

Time	*Food/Beverage*	*Location*

How much of the following beverages do you drink each day or week? (please specify cups, ounces, cans, etc.)

Water: _____ Soda (regular or diet) _____

Coffee/ Tea _____ Other beverages _____