CHERYL'S THERAPEUTIC NUTRITION
NEW CLIENT INFORMATION FORM

Please print clearly:

Name_____ Date_____

Address _____ Apt.# _____

City _____ State_____ ZIP_____

Home Phone (_____) _____-_____ Work Phone (_____) _____-_____

Cell Phone (_____) _____-_____

e-mail address: _____

REFERRED BY:_____

Occupation _____ Employer_____

Date of Birth _____ Age ____ Sex: M/F Height _____ Weight _____

Overall health (circle one): Excellent / Good / Fair / Poor / Other: _____

Chief complaint (reason you are here): **(use separate sheet if more room needed)**

_____

_____

Previous treatments for this complaint _____

_____

_____

Other complaints or problems: **(use separate sheet if needed)**_____

_____

Current medications or supplements being taken: **(use separate sheet if needed)** _____

_____

_____

Do you get yearly vaccinations? _____

_____

Dental Issues (how many fillings, root canals, bridges?) _____

_____

Are you currently under the care of a physician or other health care professionals? **(If yes, please give name and date of last visit):**

_____

Rate your stress level on a scale of 1 to 10 (with 10 being extremely stressed) _____

What could you do to realistically reduce your stress level? _____

_____

Emotional/Physical stressors: _____

_____

Do you smoke, drink coffee, use diet drinks or food or use alcohol? **(If yes, indicate how much)**
Cigarettes ____ how long ___ yrs Coffee _____/day Alcohol ____/month Diet drinks ____

How much water do you drink per day? _____ Is it tap water? _____ Do you drink diet drinks or things with Aspartame or Sucralose (artificial sweeteners)? How much? _____/day

Do you crave sweets or salty foods? If so what kinds? _____
_____
How many hours do you sleep at night? _____
What kind of exercise do you do?_____
Where did you grow up? _____
Do you have any scars (childbirth, surgery, injury)? _____
_____
List any major illnesses (with approx. dates): _____
_____
_____
List any surgery or operations with approx. date:_____
_____
_____
Past accidents or injuries (including auto and work):_____
_____
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Marital Status: S M D W Name of Spouse _____
Describe health of spouse: _____Number of children if any: _____

Name of Child	Age	Sex	Any physical conditions or concerns?
_____	____	M/F	_____
_____	____	M/F	_____
_____	____	M/F	_____

Any family history of serious illnesses (circle those which apply): Cancer / Diabetes / Heart / Other _____
_____
Any household pets or other animals you or family members are in close contact with:
_____

Do you see yourself REALISTICALLY taking the necessary steps (meal preparation, dietary changes, certain food avoidance) in the near future to improve your overall health and well being? YES _____ NO _____
EXPLAIN:_____

Dietary Intake for 3 days (include beverages please)
This is mandatory as I will not be able to help you with recommendations without knowledge on what you are eating:

Breakfast:	**Breakfast:**	**Breakfast:**
Snacks:	**Snacks:**	**Snacks:**
Lunch:	**Lunch:**	**Lunch:**
Snacks:	**Snacks:**	**Snacks:**
Dinner:	**Dinner:**	**Dinner:**
Snacks:	**Snacks:**	**Snacks:**
Beverages:	**Beverages:**	**Beverages:**