2001 Marcus Ave.
Suite E240
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Name _____Date _____ Marital Status _____ Age _____

Reason for today's visit_____

# of people living in your household _____ # of children _____

Check off any Health issues that apply:

Diabetes	Irritable Bowel Syndrome	Polycystic Ovarian Disease
Overweight/Obesity	Diverticulosis/itis	Food Allergies
Heart Disease	GERD/Reflux	SIBO
High Cholesterol/TG	Chronic Headaches/Migraines	Constipation
High Blood Pressure	Renal Disease	Crohn's Disease
Cancer	Binge Eating	Colitis
Sleep Apnea	Eating Disorder	Celiac Disease
Thyroid Disease	Depression	Sress

Relevant Surgeries_____

FAMILY HISTORY of above conditions _____

Current Medications _____
_____

Vitamin/Mineral/Herbal Supplements _____
_____

Recent Lab Data – if available

Cholesterol _____ LDL _____ HDL _____ TG _____

Fasting Blood Sugar _____ HemoglobinA1c _____ Blood Pressure _____

Nutrition and Exercise Habits

Height _____ Weight _____ Desired Weight _____ BMI (_____) leave blank

Have you lost or gained weight recently? YES ____ NO _____

If yes, explain _____

Do you smoke _____ If yes, How much? _____

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STACIE CASTLE
nutrition

How much alcohol do you drink/day _____ per/week _____

Do you have any religious/cultural factors affecting your diet? _____

What is your previous diet experience? _____

Who is responsible for the food purchase _____ the preparation _____

How many times do you eat out per week _____

How many home cooked meals do you eat at home per week _____ Take out _____

Do you exercise _____ How often and for how long _____

What types of exercise do you do _____

On a scale of 1 to 10 how motivated are you to change your diet or to lose weight? _____
Using the same scale how confident are you? _____

What food do you like? _____

What food do you dislike? _____

Food Recall: What have you eaten in the last 24 Hours? Or On a Typical Days Intake.

Breakfast	Snack	Lunch	Snack	Dinner	Snack