

1000 Heritage Center Circle, Round Rock, TX, 78664

512-368-7257 (office) 512-377-9840 (fax)

As a Registered and Licensed Dietitian, Your Nutrition Guru can provide nutrition education for a variety of health concerns including but not limited to weight management, dyslipidemia, hypertension, diabetes, metabolic syndrome, performance nutrition, stroke, and heart attack.

**Client Information:**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_

Referring Physician:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_ Gender:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_ Zip Code:\_\_\_\_\_\_\_\_\_\_\_\_

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Drivers License #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employers Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City/State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Insurance Policy Holder Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group/Policy Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Previous Nutrition Education: \_\_\_\_\_Yes \_\_\_\_\_No

If yes, please provide the name of the nutrition educator, dates of education and topics discussed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



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**Initial Consultation Patient History**

**Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Reason for initial visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you currently have or previously had any of the following conditions (check all that apply)?

\_\_\_Diabetes: Type 1\_\_\_\_ Type 2\_\_\_\_ Gestational \_\_\_\_

\_\_\_Cancer: Type and stage\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_Cardiovascular Disease \_\_\_Hypertension

\_\_\_High Cholesterol \_\_\_Stroke

\_\_\_Heart Attack \_\_\_Osteoporosis

\_\_\_Depression \_\_\_Anxiety

\_\_\_Hyper/Hypothyroidism \_\_\_Liver Disease

\_\_\_Hepatitis \_\_\_Kidney Disease

\_\_\_Metabolic Syndrome \_\_\_Hypo/hyperglycemia

\_\_\_Alzheimer’s Disease \_\_\_Parkinson’s Disease

\_\_\_Dementia \_\_\_Arthritis

\_\_\_Anemia

Have any of your immediate family members (mother, father, brother, sister) ever had any of the following conditions?

\_\_\_Diabetes: Type 1\_\_\_\_ Type 2\_\_\_\_ Gestational \_\_\_\_

\_\_\_Cancer: Type and stage\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_Cardiovascular Disease \_\_\_Hypertension

\_\_\_High Cholesterol \_\_\_Stroke

\_\_\_Heart Attack \_\_\_Osteoporosis

\_\_\_Depression \_\_\_Anxiety

\_\_\_Hyper/Hypothyroidism \_\_\_Liver Disease

\_\_\_Hepatitis \_\_\_Kidney Disease

\_\_\_Metabolic Syndrome \_\_\_Hypo/hyperglycemia

\_\_\_Alzheimer’s Disease \_\_\_Parkinson’s Disease

\_\_\_Dementia \_\_\_Arthritis

\_\_\_Anemia

Are you currently experiencing any bone or joint pain? \_\_\_Yes \_\_\_No

Do you have any previous injuries? \_\_\_Yes \_\_\_No

If yes, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had surgery? \_\_\_Yes \_\_\_No

If yes, please describe and provide dates of when the surgery/surgeries was/were: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

On average, how many hours per day do you spend **Free Time** watching television, playing video games, working on a computer or tablet?

\_\_\_<1 hour \_\_\_1-2 hours \_\_\_2-3 hours \_\_\_>3 hours

On average, how many hours per day to you spend **Working** at a computer, seated in a desk, on a tablet?

\_\_\_<4 hours \_\_\_4-6 hours \_\_\_6-8 hours \_\_\_>8 hours

Please describe your current physical activity level and abilities:

\_\_\_I am not able to engage in physical activity.

\_\_\_I am physically able to engage in physical activity, but am not currently active.

\_\_\_I engage in light to moderate physical activity on a regular basis.

\_\_\_I engage in vigorous physical activity on a regular basis.

If you are currently physically active, please list the types of activity you engage in and the frequency and duration of these activities: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please provide the following information on all current medications and supplements that you take:

**Medication/Supplement Name: Dose: Reason for Taking:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*\*If you need more space for medication/supplement information, please provide it on the back of this form.

How would you describe your current health status?

\_\_\_I am an extremely healthy person

\_\_\_I am a generally healthy person

\_\_\_I have a few health concerns, but I feel I am in overall good health

\_\_\_I have many health concerns and am worried about my future

\_\_\_Although I am free of disease, I don’t feel I have healthy habits

How would you describe your current motivation for exercise?

\_\_\_I do not exercise and am not interested in exercising

\_\_\_I do not exercise, but am considering starting

\_\_\_I exercise and plan to continue to the exercise regimen I currently do

\_\_\_I exercise and am interested in changing and improving my current regimen