New Energy Nutrition
Christine P. Mastrangelo, RDN LDN
4 Quail Run Hollow Newburyport, MA 01950
PH: 781.248.8238 Email: Christine@ne-nutrition.net
www.newenergynutrition.com

New Patient Case Taking Form
Current Date:_____

Title (Mr.,Mrs.,Ms, Dr.)_____
Patient First Name:_____ Patient Middle Initial:_____
Patient Last Name:_____

Home Phone:_____
Mobile Phone:_____
Do we have permission to leave messages on voicemail or in text? YES NO

Email Address:_____

Assigned gender at birth:_____
Date of birth:_____ Age:_____
Marital Status:_____
Occupation:_____

Emergency contact (or responsible party for minor- name and contact):_____
_____

Primary Care Doctor: (Name, Address, Phone:)_____
_____

Referring Physician or clinician (if different from above- Name, Address, Phone):_____
_____

Do we have permission to contact your primary care physician or the referring physician? YES NO

Insurance Provider: _____
Member Number:_____ Group Number:_____
Subscriber Name: _____ Date of birth:_____

Anthropometrical data

Height:_____
Current Weight:_____
Historical Weight:_____
Stated Ideal body Weight: _____
Recent weight gain: YES NO
Recent weight loss: YES NO
Are you comfortable at your current weight? YES NO

SECTION 1:

Primary Health Concerns or reasons for seeking services (prioritize in order of importance if possible):

1.
2.
3.
4.
5.
6.

Other Health and Wellness Goals to discuss?

SECTION 2:

2.1 Do you have known allergies to foods? YES NO

2.2 Please List food and allergic response:

2.3 Are you concerned you may have undiagnosed food allergies? YES NO

(If Yes) Please List foods and allergic response:

2.4 Do you have any known medication allergies? YES NO

Please List and indicate reaction:

2.5 Do you have any known seasonal or environmental allergies? YES NO

Please List and indicate reaction:

SECTION 3:

List any pharmaceutical medications you are currently taking

Medication:	Daily Dose:	How long have you been taking?

List any nutritional/ vitamin / herbal supplements you are currently taking

Supplement:	Daily Dose:	How long have you been taking?

SECTION 4:

Health Check of Symptoms (check the box to the left of those that apply):

THROAT

	Swollen glands
	Frequent strep infections
	Dryness
	Frequent viral infections
	Tonsil / adenoid removal
	Tonsil stones
	Hoarseness

EYES

	eyestrain
	light sensitivity
	blurred vision
	watery eyes
	red eyes
	eye pain
	Frequent infections

MUSCULOSKELETAL SYSTEM

	Frequent cramps in legs / feet
	Back pain / stiffness
	Numbness, pins / needles
	Joint pain or weakness

EARS, NOSE & SINUS

	deafness
	Ear noise / tinnitus
	Ear wax
	Frequent ear infections
	Loss of smell
	Blocked nose
	Frequent sinus issues / infections
	sneezing
	allergies
	Nose bleeds

SKIN & HAIR

	acne
	eczema
	dry / flaky
	hair loss
	Excessive sweating
	itching
	dandruff
	redness
	warts

EMOTIONAL

	Depression
	anxiety
	restlessness
	Excessive worry
	Compulsive thinking
	nightmares
	Mood swings
	Insomnia

HEAD, NECK & SHOULDERS

	Aching			Joint Pain
	Tension			Migraines
	Arm Pain			Other Head pain
	Shoulder pain / frozen			Dizziness
	Numbness / Tingling			Fainting
	Cold hands/ feet			POTS

MOUTH, TEETH & GUMS

	toothache
	Lost / loose teeth
	Abscesses
	Mouth ulcers / canker sores
	Mercury fillings
	Bleeding gums
	Grinding teeth
	Dry mouth
	Wisdom teeth removal / surgery
	Taste changes
	Yeast or thrush

CHEST

	pains
	tightness
	Difficulty breathing
	Chronic cough
	wheezing
	palpitations
	Cardiac disease diagnosis
	Cold hands/ feet
	High or low blood pressure
	Varicose veins (self or family)
	Dizziness upon standing

URINARY SYSTEM

	Frequent thirst
	Frequent urination
	Waking at night to urinate
	Frequent infections
	itching
	Burning with urination
	Frequent "accidents"
	Restricted flow
	Strong smelling urine
	Blood in urine

NERVOUS SYSTEM

	Weakness
	Poor Circulation
	Loss of Balance
	Memory loss
	Brain "fog"
	Attention Issues
	Numbness in extremities
	coldness

MALE SYSTEMS

	Erection concerns
	Lower back pain
	Sciatica
	Testicular pain
	Prostate problems
	Waking at night to urinate
	Changes in urine stream
	Frequent infections
	Difficulty conceiving

FEMALE SYSTEMS

	Menstrual irregularities			Loss of libido
	PMS			Abnormal discharge
	PMDD			infections
	Cramps			infertility
	menopause			Breast lumps, cysts, adenomas
	Hot flashes			Breast tenderness
	Frequent urination at night			Excessive facial hair

DIGESTIVE SYSTEMS

	acidity			Loss of taste
	burning			vomiting
	reflux			bloating
	constipation			diarrhea
	Diagnosis "irritable bowel"			fissures
	indigestion			Change in stool color
	nausea			Excessive flatulence
	Sugar cravings			Excessive burping
	Bad Breath			Sweat has strong odor
	Diagnosis SIBO or SIFO			Take medications for GI concerns

SECTION 5:

5.1 MEDICAL HISTORY:

Current Medical Diagnosis:

5.2

Details of operations:	What?	Date?	Complications or details?
Details major adult illnesses:	What?	Date?	Complications or details?
Details major childhood illnesses:		Approx Age?	Complications or details?

5.3 Have you frequently been prescribed antibiotics, antifungals, steroids in the past or currently? YES NO

5.4 When was the last time (approx. dates)?_____

5.5 What was the diagnosis?_____

5.6 Which medications were prescribed?_____

5.7 Length of time?_____

5.8 Any other helpful details?_____

5.9 Have you ever been diagnosed with Lyme Disease or one of the Lyme co-infections? YES NO (explain):_____

5.10 Have you ever been diagnosed with a strep infection? YES NO

5.11 Did you have "typical" symptoms of strep throat as a child? YES NO

5.12 Did you have frequent ear, nose, and throat infections as a child? YES NO

5.13 Have you lived or worked in a building that is known to have mold? YES NO

5.14 Have you ever been exposed to a significant amount of environmental toxins (pesticides due to work or living on a farm, polluted water)? YES NO

5.15 Do you have mercury fillings? YES NO

5.16 Do you live in a town that uses fluoride in the water? YES NO

SECTION 6:

EXERCISE:

6.1 How often do you exercise in a week?_____

6.2 What kinds of exercise do you do?_____

6.3 Do you typically feel better or worse after exercising?_____

6.4 Do you have physical pain that limits your ability to exercise (elaborate)?_____

_____

6.5 Do you feel you have compulsive behaviors around exercise? YES NO

SECTION 7:

RELAXATION AND SLEEP:

7.1 What kinds of activities do you do to relax?_____

7.2 How often do you engage in these activities?_____

7.3 How many hours of sleep do you get on average each night?_____

7.4 Do you wake up feeling well rested? YES NO

7.5 Do you fall asleep easily? YES NO

7.6 Do you find yourself worrying or overthinking at bedtime: YES NO

SECTION 8:

MOOD PANIC:

8.1 Do you suffer from panic attacks? YES NO

8.2 How often do you have what you would describe as panic attacks?_____

8.3 Do you know what typically brings on a panic attack?_____

8.4 Was there a specific event that brough on the initial panic attack?_____

_____

8.5 On a scale of 0 (none) to 10 (extreme) what would you say is your typical anxiety level on any given day (circle one)?

0 1 2 3 4 5 6 7 8 9 10

8.6 What are your most common symptoms of a panic attack (dizziness, difficulty breathing, heart palpitations, vomiting, sweating etc.)?_____

_____

8.7 Is there anything that helps resolve a panic attack faster or that calms you?_____

_____

8.8 Is there anything that is triggering or can make a panic attack worse?_____

_____

SECTION 9:

MOOD DEPRESSION:

9.1 Do you have a diagnosis of depression or feel you have depression? YES NO

9.2 On a scale of 0 (none) to 10 (extreme) what would you say is your typical depression level on any given day (circle one)?

0 1 2 3 4 5 6 7 8 9 10

9.3 Do you feel your depression is situational (meaning, it came on after an event or trigger)?_____

_____

9.4 How long has this depression been going on?_____

9.5 Do you have significant stressors in your life? YES NO

(explain):_____

9.6 Do you recall feeling sad as a child? YES NO

9.7 Do you know if you have a family history of mental illness? YES NO

(explain):_____

9.8 Are you on, or have you ever been on in the past, a medication for depression? YES NO

(medication / dosage/ length of time on):_____

9.9 Do you look forward to most days? YES NO

9.10 Do you have things that you enjoy doing daily? YES NO

9.11 Do you have a diagnosis of OCD or do you think you exhibit compulsive behaviors? YES NO

(explain):_____

9.12 Have you ever been diagnosed with having, or do you think you may have, an eating disorder? YES NO

(explain):_____

_____

9.13 On a scale of 0 (poorly) to 10 (great) how do you feel overall about your physical body? (circle one)?

0 1 2 3 4 5 6 7 8 9 10

SECTION 10:

ENERGY

10.1 On a scale of 0 (none) to 10 (extreme) what would you say is your typical energy level on any given day (circle one)?

0 1 2 3 4 5 6 7 8 9 10

10.2 At what time of day do you feel like you have to most energy?_____

10.3 Is there a time of day when you feel you struggle the most with energy?_____

SECTION 11:

FEMALE REPRODUCTIVE:

11.1 At what age did you get your first menstrual cycle?_____

11.2 Are you still menstruating? YES NO

11.3 Is your cycle regular? YES NO Number of days in cycle:_____

11.4 How many days do you bleed?_____

11.5 Do you have a heavy or light flow?_____

11.6 Do you have PMS symptoms that interfere with your life? YES NO
(explain):_____

11.7 How many pregnancies have you had?_____

11.8 Have you had issues trying to conceive?_____

Other:

SECTION 12:

12.1 FOOD DIARY

Dietary intake in a typical day:

On rising	Breakfast	Mid-morning snack
Lunch	**Mid-afternoon snack**	**Dinner**
After dinner snack	**Bedtime**	**Other?**

12.2 How much water do you drink in a day?_____

12.3 Do you drink soda, coffee, tea or other beverages?_____

12.3 Do you drink alcohol? How often? How much?_____

12.4 List any "comfort" foods:_____

_____

_____

12.5 List any foods or food groups you will not eat:_____

_____

_____

ANY OTHER INFORMATION YOU WOULD LIKE US TO KNOW: