Finding Freedom Nutrition and Counseling, LLC
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New Client Information

Patient Name _____ Date of Birth _____/_____/_____

Gender: ____Male ____Female _____Undecided Social Security _____-____-_____

Street Address: _____

City: _____ State: _____ Zip Code:_____

Home Phone: ( ) _____ Cell Phone: ( ) _____

E-Mail Address: _____

Marital Status: _____ Single _____Married _____Divorced Children: _____Yes _____No Ages: _____

Occupation: _____ Employer: _____ Hours Worked/Week: _____

Emergency Contact: (Name, Phone Number, Relationship to client):_____

Have you worked previously with a dietitian? _____ Yes _____ No If yes: What was helpful?

_____

_____

What are you looking for in a dietitian? _____

_____

Do you currently have a Therapist? _____Yes _____ No If yes: Are you willing to sign a release for contact of information? _____ Yes _____No Name: _____ Number: _____

Do you currently have a Primary Care Physician? _____Yes _____ No If yes: Are you willing to sign a release for contact of information? _____ Yes _____No Name: _____ Number: _____

Do you currently have a Psychiatrist? _____Yes _____ No If yes: Are you willing to sign a release for contact of information? _____ Yes _____No Name: _____ Number: _____

I, _____, (print name), agree to allow Aisha Kashif Lubinski to contact my above treatment team for continuation of care and best practice. I understand that by agreeing to this, both Aisha Kashif Lubinski and my team member can communicate details of my case including but not limited to: behaviors, weight, therapeutic goals, work, and assignments. I understand that if I wish to revoke these releases, I may communicate this verbally and in writing to Aisha Kashif Lubinski, RD LD at any time.

Signature of client _____ Date: _____/_____/_____

If under 18, Legal Guardian Signature: _____ Date _____/_____/_____

Health and Nutrition History

Height: _____ ft _____ inches Weight: _____ lbs. (ok if unknown)

Weight History:

I have been able to maintain a weight of _____ for a period of _____(weeks, months, years)

Highest Wt: _____ When was this? _____ (age, month, year)

Lowest Wt: _____ When was this? _____ (age, month, year)

Have you gained or lost weight in the past 1-3 months? If Yes, How much? _____ Increase _____ Decrease

I believe a normal healthy weight for myself would be: _____ lbs

If you are a female, are you currently having regular periods? _____Yes _____No

Are you pregnant _____ Yes _____No My last period was _____ My cycles last _____ days

Do you: (Circle all that apply) Own Use Borrow a scale on a regular basis to obtain your weight?

My current health status is: _____Excellent _____Good _____Fair_____ Poor

Have you been diagnosed or treated for any respiratory, cardiovascular, gastrointestinal, endocrine, or mental health diseases or disorders? If yes, please list:_____

_____

Surgical History (type and year): _____

_____

List any medications you are currently taking and dosage: _____

_____

List any vitamins or supplements you are currently taking: _____

_____

Do you have any allergies or intolerances? _____Yes _____No If yes, please list and provide documentation: _____

_____

_____

Please identify any other health history that is important for treatment team to know (family disease history etc): _____

_____

_____

_____

_____

Are you currently a vegetarian or vegan? _____ Yes _____No If yes, please explain what lead you to begin practicing as vegetarian/vegan:_____

_____

My safe foods are: _____

My fear foods are: _____

My binge foods are: _____

Please identify the behaviors you currently struggle with and the frequency of each:

Behavior	Frequency	When did this behavior begin?
Restriction		
Binge		
Purge		
Laxatives		
Diuretics		
Rumination		
Chewing and Spitting		
Self Harm		
Exercise		
Hide Hoard or Steal Food		
Diet Pills		

A typical day with the food/fluid from the time you wake up until you go to bed looks like: (please include any behaviors used)

Identify any rituals you engage in: _____

What is your relationship with exercise? _____

_____

_____

Do you feel comfortable with the following skills:

Skill	Yes	NO
Grocery Shopping		
Meal Planning		
Cooking		
Eating meals at restaurants		
Eating meals with others		

Did you believe you were overweight as a child: _____Yes _____No If yes, how does this play a role in your eating disorder or relationship with food?_____

_____

_____

What is your theory as to why you have an eating disorder or disordered eating? _____

_____

_____

_____

Does anyone else in your family struggle with disordered eating or an eating disorder? _____Yes _____ No If yes, please identify who and how they struggle: _____

_____

What is your motivation for change? _____

_____

What do you want this change to look like? _____

_____

_____

Please list any other information you believe to be important to understand you or your struggles with food: _____

_____

_____

_____

_____