**ID:**
**Name:**
**DOB:**

Please fill out as much of this questionnaire as possible. All information will be kept confidential. Your answers will help us to understand your medical history, so that we can provide you with the best nutrition care possible. If you cannot answer any of the questions, please leave them blank or write "N/A". Thank you for your help.

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## Demographic Information

Please enter your current details in the fields below:

**How did you hear about us?**
**Reason for visit:**
**Treatments tried:**
**Date of birth:**
**Address:**
**City:** **State:** **Zip code:**
**Primary phone number:** **Secondary phone number:**
**Email address:**
**Preferred contact method/s:** *Email-* Yes No *Phone-* Yes No
**Can we leave a message:** Yes No
**Marital status:**
**Highest level of education:**
**Occupation:** **Retired:** Yes No
**Work hours:**
**Members of household:**

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## General Health Information

Please enter your insurance details, primary care physician and other important healthcare providers:

**Primary insurance name:**
**Type of plan:** **Phone number:**
**Insured's name:** **DOB:**
**Relationship:**
**Specialist co-pay:** $
**Membership ID number:** **Group ID number:**

**Secondary insurance name:**
**Type of plan:** **Phone number:**
**Insured's name:**
**Relationship:** **DOB:**
**Specialist co-pay:** $
**Membership ID number:** **Group ID number:**

**Primary physician name:** **Phone number:**
**Address:**
**Date of last physical:** **Date of last blood test:**
**Other important healthcare providers:**

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## Background Information

Please select the symptoms or behaviors below that you experience now or in the past. All answers will be kept confidential.

| Symptoms/Behavior | Current | Past | Notes |
|---|---|---|---|
| Overeat/binge eat | Yes No | Yes No | |
| Under-eat/restrict food intake/fast | Yes No | Yes No | |
| Vomit after eating | Yes No | Yes No | |
| Have the impulse to vomit after meals | Yes No | Yes No | |
| Feel guilty after eating | Yes No | Yes No | |
| Like my stomach to be empty | Yes No | Yes No | |
| Feel compelled to exercise | Yes No | Yes No | |
| Think about burning up calories when I exercise | Yes No | Yes No | |
| Abuse laxatives | Yes No | Yes No | |
| Abuse diuretics | Yes No | Yes No | |
| Use enemas | Yes No | Yes No | |
| Use diet pills | Yes No | Yes No | |
| Use drugs/alcohol to control appetite | Yes No | Yes No | |
| Abuse insulin | Yes No | Yes No | |
| Completely avoid certain foods e.g. foods high in carbohydrate | Yes No | Yes No | |
| Aware of the calorie content of foods I eat | Yes No | Yes No | |
| Eat diet foods | Yes No | Yes No | |
| Follow diets/engage in dieting behaviour | Yes No | Yes No | |
| Eat in the middle of the night | Yes No | Yes No | |
| Avoiding eating when hungry | Yes No | Yes No | |
| Chew and then spit out food | Yes No | Yes No | |
| Cut my food into small pieces | Yes No | Yes No | |
| Have food/eating rituals | Yes No | Yes No | |
| Take longer than others to each meals | Yes No | Yes No | |
| Feel that others would prefer if I ate more | Yes No | Yes No | |
| Feel others pressure me to eat | Yes No | Yes No | |
| Think about weight/food a lot | Yes No | Yes No | |
| Feel preoccupied with a desire to be thin | Yes No | Yes No | |
| Give too much time and thought to food | Yes No | Yes No | |
| Feel terrified about becoming overweight | Yes No | Yes No | |
| Feel "fat" | Yes No | Yes No | |
| Check body/appearance very often | Yes No | Yes No | |
| Feel preoccupied with the thought of having fat on my body | Yes No | Yes No | |
| Feel food controls my life | Yes No | Yes No | |
| **Other:** | Yes No | Yes No | |
| **Other:** | Yes No | Yes No | |

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**First occurrence:**
**Details:**

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## Binge Eating

If you binge eat, please fill out the questions below.

**Frequency of binge eating:**
**Average number of binges per day:**
**Foods eaten during binges:**
**Age when first binged:**

## Purging Behaviors

If you use purging behavior e.g. laxatives, diuretics, vomiting, to compensate for eating, please complete the following questions.

**Frequency of purging:**
**Average number of times purged per day:**
**Type of purging:**
**Age when first purged:**

## Physical Activity

Do you regularly participate in physical activity/exercise/sports? If the answer is yes, please describe below.

**Frequency of exercise:**
**Average duration:**
**Type of exercise:**

## Weight History

Please enter your current weight and height as well as information about what your weight was like in the past.

**Estimated weight:**
**Height/length:** ft in
**Recent weight gain:** Yes No
**Amount:**
**Time:**
**Recent weight loss:** Yes No
**Amount:**
**Time:**
**Lowest adult weight:** **Age:**
**Highest adult weight:** **Age:**
**Do you weigh yourself routinely?**
**Frequency:**
**How do you view your weight?**

## Females Only

If you are female, please answer the following questions.

**Age at first period:**
**Irregular periods:** Yes No
**Details:**
**Oral contraceptive use:** Yes No
**Details:**
**Date of last period:**
**Currently pregnant:** Yes No
**Due date:**
**Previous pregnancies:** Yes No
**Details:**
**Currently lactating:** Yes No
**Duration:**

## Medical History

Please provide as much detail as possible about your medical history.

**Medical history:**
**Food allergies:**
**Food intolerances and sensitivities:**
**Other allergies:**
**Past surgeries / hospitalizations:**
**Current health (rating):**

## Family Medical History

Do you have a family history of the following? Please check all that apply.

| | | |
|---|---|---|
| **Yes No** - Cancer | **Yes No** - High blood cholesterol | **Yes No** - Liver disease |
| **Yes No** - Diabetes | **Yes No** - High blood pressure | **Yes No** - Thyroid disease |
| **Yes No** - Heart disease | **Yes No** - Kidney disease | **Yes No** - Obesity |

**Other family medical history:**

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## Gastrointestinal Symptoms

Please select if you regularly experience any of the following:

| | | |
|---|---|---|
| **Yes No** - Abdominal bloating | **Yes No** - Diarrhea | **Yes No** - Nausea |
| **Yes No** - Abdominal cramping | **Yes No** - Early satiety | **Yes No** - Pain on swallowing |
| **Yes No** - Abdominal distension | **Yes No** - Excessive appetite | **Yes No** - Poor appetite |
| **Yes No** - Abdominal pain | **Yes No** - Excessive belching | **Yes No** - Retching |
| **Yes No** - Acid reflux | **Yes No** - Excessive wind | **Yes No** - Vomiting |
| **Yes No** - Bulky stools | **Yes No** - Heart burn | **Other:** |
| **Yes No** - Constipation | **Yes No** - Liquid stools | **Other:** |

## Medication & Supplements

Please list all prescription and over-the-counter medications, vitamin, mineral and nutritional supplements, herbs/botanicals and diet aids you are currently taking.

| Name of Medication / Supplement | Reason | Dose & Frequency |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

## Lab Results

Please enter or upload your most recent lab results below:

**Abnormal Lab results:**

**Diagnostic studies:**

## Daily Habits

Please describe below your caffeine and alcohol intake, smoking status and recreational drug use.

**Regular caffeine intake**: Yes No **Type:** **Amount:**

**Frequency of alcohol intake:** **Type:** **Quantity:**

**Current smoking status:** **Amount:**

**Past smoking status:** **Amount:**

**Regular recreational drug use:** Yes No

**Problems with alcohol or drug abuse:** Yes No

**Received treatment for substance abuse:** Yes No

**Details:**

---

## Stress

On a scale from 1-10 with 10 being the highest, how would you rate your daily level of stress?

**Stress rating (0 = no stress & 10 = extreme stress):**

**Details:**

---

## Sleep

Based on your sleep habits during the past month only, how many hours of sleep, on average, do your get on week nights and weekend nights?

**Amount of sleep on weeknights:** **Amount of sleep on weekend nights:**

---

## Physical & Psychological Complications

Please check all following that apply.

| | |
|---|---|
| **Yes No** - Anemia | **Yes No** - Impaired concentration & memory |
| **Yes No** - Anger / irritability | **Yes No** - Infertility |
| **Yes No** - Anxiety / panic attacks | **Yes No** - Menstrual irregularities |
| **Yes No** - Blood in vomit | **Yes No** - Muscle cramps |
| **Yes No** - Changes to hair, skin and / or nails | **Yes No** - Muscle loss and weakness |
| **Yes No** - Chronic inflamed or sore throat | **Yes No** - Obsessive compulsive symptoms |
| **Yes No** - Decreased self-esteem | **Yes No** - Osteopenia / osteoporosis |
| **Yes No** - Dehydration | **Yes No** - Pancreatitis |
| **Yes No** - Dental problems | **Yes No** - Peptic ulcers |
| **Yes No** - Depression | **Yes No** - Reflux |
| **Yes No** - Diarrhea | **Yes No** - Peptic ulcers |
| **Yes No** - Edema (fluid retention) | **Yes No** - Pancreatitis |
| **Yes No** - Family conflict / relationship struggles | **Yes No** - Self harm behaviors |
| **Yes No** - Fatigue, lethargy | **Yes No** - Sleep disturbance |
| **Yes No** - Frequent injuries | **Yes No** - Social anxiety / social isolation |
| **Yes No** - Growth of lanugo (fine hairs) | **Yes No** - Swollen salivary glands |
| **Yes No** - Headaches | **Yes No** - Tingling/numbness |
| **Yes No** - Heart irregularities | **Other:** |

## Food Recall

What do you usually eat in a 48-hour period? Please write down all the food and beverages you eat in the next 48 hours. Enter the description and amount of each item as precisely as you can.

**Date:**

| Meal | Time | Food/Beverages Consumed |
|---|---|---|
| Breakfast | | |
| Snack | | |
| Lunch | | |
| Snack | | |
| Evening meal | | |
| Evening snack | | |
| Other snacks | | |
| Other beverages | | |

**Date:**

| Meal | Time | Food/Beverages Consumed |
|---|---|---|
| Breakfast | | |
| Snack | | |
| Lunch | | |
| Snack | | |
| Evening meal | | |
| Evening snack | | |
| Other snacks | | |
| Other beverages | | |

## Diet History

Please answer the following questions about your diet and eating habits.

**Food likes:**

**Food dislikes:**

**Eating out frequency:** **Details:**

**Dietary restrictions / limitations:**

**Grocery shopping:**

**Meal preparation and cooking:**

**Foods cravings:**

## Other Information

Is there any other information that you think we should know about?

**Other information:**