Medical History for Nutrition Counseling

Name _____Today's Date_____

Mailing Address _____City_____State _____ Zip_____

Street Address_____City_____ State_____Zip_____

Home Phone _____ Cell Phone _____

Email _____

Birth Date _____ Age_____ Occupation_____

Physician's Name _____ Referred By _____

Height _____ Weight _____ Goal Weight _____

Please answer the following questions as completely as possible.

What are your health concerns and/or *goals*? _____
_____

What do you want to gain from your visits working with Daniella?
_____

How much water do you drink per day? _____ (approx. ounces)

What type of water do you drink? _____(e.g.: bottled, tap)

What type of water filter do you use at home? _____

Are you currently following any dietary recommendations by your physician or other practitioners? If so, what are they?

_____

_____

Are you allergic to any medications? NO YES _____

Are you allergic to any foods? NO YES _____

Are you allergic to pollens, yeast, or molds? NO YES _____

How often do you exercise? _____ days/week

What type(s) of exercise? _____

Are you currently getting enough sleep? NO YES How many hours? ____

How many meals do you eat each day? _____

Do you eat breakfast? NO YES _____

What foods do you crave? _____

What do you normally eat daily?

Breakfast_____

Lunch_____

Dinner_____

Other_____

Please fill in the amount of use of the following.

Cigarettes	_____ packs per day
Cigars	_____ per week
Coffee	_____ cups per day
Soft Drinks	_____ servings per week
Alcohol	_____ servings per week
Chewing Tobacco	_____ times per day
Pain Relievers	_____ times per month
Recreational Drugs	_____ times per month

Please circle any health conditions, which you have had, or are now experiencing. Please circle 'P' for past and 'C' for currently experiencing.

Acne P C	Drug Addiction P C	Low Blood Pressure P C
Alcoholism P C	Eating Disorders P C	Memory Loss P C
Allergies P C	Eczema P C	Menstrual Cramps P C
Anorexia P C	Edema P C	Migraine Headaches P C
Arthritis P C	Fatigue P C	Panic Attacks P C
Asthma P C	Fibromyalgia P C	Parasites P C
Binge Eating P C	Gallbladder Disease P C	PMS P C
Bronchitis P C	Headaches P C	Pregnancy P C
Bulimia P C	Heart Disease P C	Shingles P C
Cancer P C	Heart Palpitations P C	Sinusitis P C
Chemical Sensitivity P C	Hepatitis P C	Skin Disorders P C
Closet Eating P C	Herpes P C	Sleep Apnea P C
Cold Sores P C	High Blood Pressure P C	Stress P C
Colon Disorders P C	HIV/Aids P C	Thyroid Disorders P C
Constipation P C	Hormonal Problems P C	Ulcers P C
Depression P C	Hypoglycemia P C	Water Retention P C
Diabetes P C	Hysterectomy P C	Weight Gain P C
Diarrhea P C	Infertility P C	Weight Loss P C
Digestive Problems P C	Liver Disease P C	Yo-Yo Dieting P C

Please list any other medical conditions you have experienced in the past or are now experiencing.

_____
_____
_____
_____
_____

*Please list all medications you are currently taking.**

_____
_____
_____
_____
_____
_____

*Please list any supplements (vitamins, minerals, herbs, etc.) that you are currently taking or email a photo of your supplements to Daniella.**

_____
_____
_____
_____
_____
_____
_____
_____

*If you have too many medications or supplements to list here, please bring them to your next appointment or take a photo of them and email to daniellachace@gmail.com.

Agreement
All information that I have provided is true and accurate to the best of my knowledge. I will provide any new health related information as it occurs during the course of my nutrition counseling. I authorize the release of information from my other health provider's medical records. I understand that all information will be kept confidential.

Signature_____ Date _____