Daniella Chace, MSc, CN
Medical History for Nutrition Counseling

Name_____Today's Date_____

Mailing Address _____City_____State _____Zip_____

Street Address_____City_____ State_____Zip_____

Home Phone_____Cell Phone_____

Email_____

Birthdate _____Age_____Occupation_____

Physician's Name_____Referred By_____

Height____ _____Weight_____Goal Weight_____

Please answer the following questions as completely as possible.

What are your health *goals?*

_____

_____

_____

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

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

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

Are you currently following any dietary recommendations from 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 pollen? NO YES _____

How often do you exercise? _____

What type 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
Vaped Products	_____ times per day
Pain Relievers	_____ times per month
Recreational Drugs	_____ times per month

Please list all medications you are currently taking.*

_____

_____

_____

_____

_____

Please list all supplements you are currently taking.*

_____

_____

_____

_____

_____

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

Please circle any health conditions, which you have had in the past, 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 are now experiencing.

_____

_____

_____

_____

_____

_____

_____

_____

Please print and mail the completed Medical History Form to Daniella prior to your session:

Daniella Chace
2021 San Juan Ave
Port Townsend WA. 98368

Or print and scan to email back to daniellachace@gmail.com

Thank you for taking the time to fill out this form, which is a tool that will help me work toward solving your health issues. I look forward to our upcoming session and helping you to feel better soon!

Yours,
Daniella