

# NORTHEAST NUTRITION

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To Client:

Please complete the following form and bring it with you to your first appointment.

## New Patient Intake Form

### General Information:

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Gender: \_\_\_\_\_

Phone #: home: \_\_\_\_\_ cell: \_\_\_\_\_ work: \_\_\_\_\_

Reason for Appointment: \_\_\_\_\_

Referred by: \_\_\_\_\_

Dr. Address: \_\_\_\_\_

### Medical History:

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Weight 1 year ago: \_\_\_\_\_

Usual Weight: \_\_\_\_\_ Lowest Weight: \_\_\_\_\_ Highest Weight: \_\_\_\_\_

Desired Weight: \_\_\_\_\_

Have you lost or gained weight recently?  Yes  No

Was this an intentional change?  Yes  No

Do you weigh yourself?  Yes  No

Are you concerned with your weight?  Yes  No

*Please indicate whether you or a family member have/had any of the following conditions:*

Disease/Condition	Self	Family	Relationship	Treatment
Asthma	_____	_____	_____	_____
Cancer	_____	_____	_____	_____
Cardiovascular Disease	_____	_____	_____	_____
Celiac Disease	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____
Eating Disorder	_____	_____	_____	_____
Food Allergies	_____	_____	_____	_____
Food Intolerances	_____	_____	_____	_____
GERD/Heartburn	_____	_____	_____	_____
Headaches	_____	_____	_____	_____
Heart Attack	_____	_____	_____	_____
High Cholesterol	_____	_____	_____	_____
Hypertension (HBP)	_____	_____	_____	_____
Intestinal Problems	_____	_____	_____	_____

Kidney Disease	_____	_____	_____	_____
Menstrual Problems	_____	_____	_____	_____
Mental Health Issues	_____	_____	_____	_____
Obesity	_____	_____	_____	_____
Osteoporosis	_____	_____	_____	_____
Thyroid Disorder	_____	_____	_____	_____
Other	_____			

Are you currently being treated for any medical conditions?  Yes  No  
 If yes, please specify: \_\_\_\_\_

Are you taking any medications?  Yes  No  
 Please list: \_\_\_\_\_

Are you taking any vitamin, mineral, food or herbal supplements?  Yes  No  
 Please list: \_\_\_\_\_

Have you ever been advised by your physician to follow a special diet?  Yes  No  
 What type? \_\_\_\_\_

Are you currently following that diet?  Yes  No  
 If not, indicate why. If yes, what changes have you made? \_\_\_\_\_

Do you drink alcohol?  Yes  No Number of drinks per week: \_\_\_\_\_  
 Do you smoke cigarettes?  Yes  No Amount per day: \_\_\_\_\_  
 How long have you smoked? \_\_\_\_\_ If you quit smoking, when? \_\_\_\_\_

**Dieting History:**

How many times have you tried to lose weight? \_\_\_\_\_  
 Age of first attempt: \_\_\_\_\_ Your weight at that time: \_\_\_\_\_  
 What diet did you follow? \_\_\_\_\_  
 Why did you choose that diet? \_\_\_\_\_

List other weight loss attempts:

Diet	Year	Outcome
_____	_____	_____
_____	_____	_____

**Exercise History:**

Do you exercise currently?  Yes  No  
*Circle One:* Low=0 to 30 min/day. Moderate = 30 to 60 min/day. Heavy = 1 hour or more/day.

List type, duration, frequency, and intensity of exercise activities:

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Have you exercised in the past year?  Yes  No

Do you have any physical conditions that limit your ability to exercise?  Yes  No

Please specify: \_\_\_\_\_

**Eating Patterns:**

How many days per week do you eat:

Breakfast: \_\_\_\_\_ Lunch: \_\_\_\_\_ Dinner: \_\_\_\_\_

Do you snack?  Yes  No

When? \_\_\_\_\_

Do you buy or pack your lunches?

Buy # days per week: \_\_\_\_\_  Pack # days per week: \_\_\_\_\_

Do you eat out?  Yes  No

How many meals per week? \_\_\_\_\_

What restaurants do you usually choose? Indicate all take out, banquets, meetings, etc.

1. _____	4. _____	7. _____
2. _____	5. _____	8. _____
3. _____	6. _____	9. _____

Who usually prepares the food at home? \_\_\_\_\_

Do you know how to cook from scratch?  Yes  No

Who does the grocery shopping? \_\_\_\_\_

Do you read food labels?  Yes  No What do you look at on the label? \_\_\_\_\_

**Goals/Expectations**

What expectations would you like to see from meeting with a dietitian/nutritionist? Circle all that apply.

- Weight Management \* Portion Size \* Disease Management \* Meal Planning \* Label Reading \* Fiber
- \* Exercise Ideas \* General Nutrition \* Healthy Food Preparation \* Carb Counting \* Low Fat
- Cooking Ideas \* Cardiovascular Health \* Seasonings \* Diabetes \* Celiac \* Food Safety \*
- My Nutritional Needs \* Dyslipidemia \* Gastrointestinal Disorders \* Hypertension (HBP) \*
- Cancer Care \* Bone and Osteoporosis \* Salt Intake

OTHER / ADDITIONAL ISSUES: