kindred NUTRITION

# New Client Information

| | | | | | |
|---|---|---|---|---|---|
| Client Name: | | | | Telephone: | |
| Street Address: | | City: | | State: | Zip: |
| DOB: | Gender: | Age: | Married/Single | Occupation: | |
| Primary Care Physician: | | Phone: | | | |
| Insurance Company: | | Policy ID #: | | Group #: | |
| Referred by: | | | | | |

## Medical History

**Diagnosis (please document all and add year of diagnosis):**

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## Medications and Supplements

| Medication | Dosage | For |
|---|---|---|
| Multivitamin | | |
| Probiotic | | |
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****Please include any herbs (Ginseng, Milk Thistle etc.)****

## Basic Anthropometrics

| Height: | Weight: | Desired Weight: |
|---|---|---|
| I have gained weight within the last year: **YES** **NO** Pounds: _____<br>I have lost weight within the last year: **YES** **NO** Pounds:_____ | | |

Weight Timeline

| **Age:** | 20-30 | 30-40 | 40-50 | 50-60 |
|---|---|---|---|---|
| **Weight Range:** | | | | |

## Exercise Assessment

Are you regularly active? **YES** **NO**

How much physical activity do you have a day? **NONE** **1-30 min** **30-60 min** **60+ min**

| Describe the type of physical activity you do (duration, effort 0-100%, days etc.) |
|---|
| |

| **How often do you eat the following foods?** | | | | |
|---|---|---|---|---|
| | **Daily/ Often** | **Occasionally** | **Rarely** | **Never** |
| **Fruit** | | | | |
| **Vegetables** | | | | |
| **Grains** | | | | |
| **Dairy** | | | | |
| **Meat** | | | | |
| **Soda** | | | | |

**<u>Eating Behavior Assessment</u> – Check all that apply**

_____ Have an inconsistent meal pattern/timing?
_____ Skip meals?
_____ Eat very fast?
_____ Eat until you are uncomfortably full?
_____ Binge or eat without being able to stop?
_____ Eat large amounts of food when you are not physically hungry?
_____ Purge by vomiting
_____ Take laxatives?
_____ Frequently eat out?
_____ Use food as a reward?
_____ Avoid any food groups?

_____ Make yourself sick because you Feel uncomfortably full
_____ Worry you have lost control over How much you eat?
_____ Have you lost more than one stone (14lbs) over the last 3 months?
_____ Believe yourself to be fat when Others say you are thin?
_____ would you say that food dominates your life?
_____ Snack Late at Night

Do you crave specific foods frequently? Yes _____ No _____

If yes, which foods? _____

Specific foods you dislike? Yes_____ No _____

If yes, which foods? _____

Do you have any food allergies? Yes _____ No _____

If yes, to what? _____

Do you have any food intolerances? Yes _____ No_____

If yes, what symptoms does it cause? _____

Do you smoke? Yes _____ No_____

If yes, how many cigarettes per day? _____

Do you drink alcoholic beverages?_____

If yes, how much/often? _____

**Do you experience any of the following? (Circle all that apply)**

**Reflux Dizziness Diarrhea Constipation Bloating Nausea Arrhythmia Vomiting Fainting**

**Hypothermia Hot Flashes Thirst Frequent Urination Constant Hunger**

Do you follow any diet rules? Yes_____ No_____

If yes, what are they? _____

## Hydration Assessment

How many cups of water do you drink in a day? _____

## For Females Only

If you are female, when did you start menstruation? _____

Are your periods consistent? _____

Are you experiencing amenorrhea (absence of period for more than 2 months)? **Yes No**

If yes when was your last period _____

## Behavior Change Assessment

On a scale of 0-10 (0 not ready at all and 10 extremely ready), how ready are you to change your eating behaviors?_____

On a confidence scale of 0-10 (same as above), how confident are you in your ability to make changes:

_____

Do you have any obstacles to change at this time:

_____

_____

_____

_____

**Goal Setting:**

Please describe your goal(s) for today's visit:

_____

_____

**If you would like to receive Kindred Nutrition's Monthly newsletter, please list your email below.**

**Email: _____**