Initial Visit Forms

Last Name: ____________________ First Name: ______________________

Home Address: ____

Date of Birth: __________________________ Age: ___________

Telephone No: Home: __________________Work: ________________________

Cell: ____________________

Email Address: ____

Name of Person
Responsible for Bill: ____

Medical Insurance: ____

Reason for Referral: ____

____

If no referral, how did you hear about us? ____________________________________

Current Doctor: _______________________ Phone: ________________________

Fax Number: _________________________

Occupation: ______________________ Employer: ______________________

Other: ____

____

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Name: ____
Occupation: ___________________________________

Height: _________ Age: _________ Sex: _____ Current weight: _________
Usual Weight for the past 6 months or a year: _____________
At what weight do you feel comfortable? _________________
Highest adult weight? ____________ Age: _____________
Lowest adult weight? ____________ Age: _____________
If pregnant what was your pre-pregnancy weight? ____________
Have you lost or gained weight recently? __________
How much? _____________Time frame? ___________

Dieting History
Have you ever tried to lose weight before? _ yes _ no
1. Type of Diet or program followed to lose weight:
____
Short-term results? ______________________
Long-term results? ____________________________
2. Type of Diet program followed to lose weight:
____
Short-term results? ____
Long-term results? ____
3. Type of Diet or program followed to lose weight:
____
Short-term results? ______________________
Long-term results? ____________________________
Additional comments you would like to add regarding "dieting" history?
____
____
____
____
____
____
Have you ever used laxatives for weight control? ____ yes ____ no
Have you ever vomited for weight control? ___yes ___ no

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Personal Medical History
Your answers on this form will help your health care provider better understand your medical concerns and conditions better. If you are uncomfortable with any question, do not answer it. If you cannot remember specific details, please provide your best guess.
Thank you!

How would you rate your general health? Excellent ___ Good ___ Fair ___ Poor___
Main reason for today's visit:
Other concerns:
Food Allergies:

In the past month, have you had little interest or pleasure in doing things, or felt down, depressed or hopeless? ___Yes ____ No

REVIEW OF SYMPTOMS: Please check any current symptoms you have.
Constitutional
___Unexplained weight loss/gain ___Unexplained fatigue/weakness

Eyes
____Blurry Vision

Ears/Nose/Throat/Mouth
____Trouble swallowing ____Difficulty chewing

Gastrointestinal
___Heartburn/reflux ____Nausea or vomiting ____Diarrhea
_____Constipation
____Pain in abdomen

Musculoskeletal
____Muscle/joint pain ____Recent back pain

Psychiatric
____Anxiety/stress _____Sleeping difficulties

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Other Recent Symptoms

___Increase thirst _____Increase appetite _____Increase urination frequency

MEDICATIONS: Prescription and non-prescription medicines, vitamins, home remedies, birth control pills, herbs, etc.

Medication Dose (e.g., mg/pill) How many times per day

____

____

____

____

____

PERSONAL MEDICAL HISTORY: Please indicate if you have or had any of the following medical problems.

____Heart disease ____Asthma/Lung disease ____High cholesterol
____Thyroid problem ____Kidney disease ____Diabetes _____Liver Disease
____Cancer: (specify): _______________ Other: ___________________________________

SURGICAL HISTORY: Please list prior operations:______________________________

FAMILY HISTORY: Please indicate the current status of your immediate family members:

Please indicate family members (parent, sibling, grandparent, aunt or uncle) with any of the following conditions:

_____Heart Disease ____Diabetes _____High Cholesterol _____Liver Disease
____Cancer

SOCIAL HISTORY

Tobacco Use

Cigarettes ___ Never ___ Quit Date
_ Current Smoker: packs/day # of yrs
Other Tobacco: _ Pipe _ Cigar _ Snuff _ Chew
Are you interested in quitting? ____ No ____ Yes

Alcohol Use

Do you drink alcohol? ___ No ___ Yes # drinks/week

Drug Use

Do you use any recreational drugs? ___ No ___ Yes

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OTHER CONCERNS
Caffeine Intake: ___ None ___ Coffee/tea/soda cups/day
Weight: Are you satisfied with your weight? ___ No ___ Yes
Diet: How do you rate your diet? ____ Good ___ Fair ___ Poor
Do you eat or drink four servings of dairy or soy daily or take calcium supplements?
___ No ___ Yes
Exercise: Do you exercise regularly? ___ No ___ Yes
What kind of exercise?
____
How long (minutes) How often?
____
If you do not exercise, why?
____

If you have recent laboratory test results, please list: Date _______________________
Total Cholesterol ________ Triglycerides ________
LDL ________ HDL ________
Glucose ________ HbA1C ________%
Blood Pressure ________ Other_____________________

Have you ever been advised by your physician to follow a special diet?
(low salt, low cholesterol, no sugar, etc) ____yes ____ no
What changes did you make at that time?
____
____
____
Have you ever worked with a dietitian/nutritionist? ____ yes ___ no
If yes, what was your experience?
____

Eating Patterns
How many meals a day do you eat?
____
Do you skip meals? _________ If yes, which ones do you skip and why?
____
____
How often do you snack? ___ Once daily ___ Twice daily ___Three Times daily

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When do you usually snack?

____

What foods do you snack on most frequently?

____

____

How many times per week do you eat at a restaurant?

____

Which restaurants do you normally choose?

____

How many meals per week do you eat at fast-food restaurants?

____

What are your favorite foods?

____

____

____

List any foods you avoid eating:

____

____

____

Do you eat standing up? ___ yes ___ no
Do you eat in the car? ___ yes ___ no
Do you eat at the table? ___ yes __ no
Do you eat with others? ___ yes __ no
Do you engage in other activities when you eat? ___ yes ___ no
Do you feel you eat fast? ___ yes ___ no
Who usually prepares the food at home? ______________________________
Do you cook? ___ yes ___ no
Who usually does the grocery shopping? ______________________________
Do you read food/nutrition labels? ___ yes ___ no
What do you look for on labels?

____

Do you, or have you ever, used food for comfort or to address other emotions?
___ yes ____ no
If yes, please elaborate:

____

____

____

Do you have a strong support system? ___yes ____no

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Who constitutes your support system? ____

Do you feel that your life/schedule often conflicts with a healthy exercise program?
___ yes ___ no

If yes, how?

____

____

Have you ever worked with a personal trainer before? ____ yes ___ no

If yes, what was your experience like?

____

THANK YOU!!

Please bring with you to your first appointment or fax or email to us before your appointment. We highly recommend you allow us to review this forms before your first appointment to save you time and make the consultation more cost effective for you. We look forward to meeting you.

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Payment:

Unless other arrangements have been made, payment is due at the time of the appointment. Cash or checks are accepted, and checks can be made payable to NutriWellness4Life.

Cancellation:

Individual appointments are scheduled for a specific time. Cancellation requires a 24 hour notice.

Medical Insurance:

Medical insurance companies may or may not provide reimbursement for nutrition services. Please check with your insurance provider regarding their policy on reimbursement for nutrition services. While *NutriWellness4Life* does not directly bill insurance companies, a form (superbill) will be provided that may be self-submitted for potential insurance reimbursement.

I, the undersigned, have read and agree to the conditions as outlined above in that:

1. I understand that I will be responsible for payment at the time services are provided by *NutriWellness4Life*.
2. I understand that a change or cancellation of my appointment requires at least 24 hours notice, or I may be charged for the appointment.
3. I understand that the paperwork I receive from *NutriWellness4Life* must be ***self-submitted*** to seek medical reimbursement.
4. I will not hold *NutriWellness4Life or Mariel Morales* liable for any damages incurred while receiving service.

Signature or responsible party: ____
Date: ____________________