www.eatfithealth.com

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New Client Information & History

(please complete form prior to visit and bring or send electronically, print or type)

***parent's please complete form for young children**

CLIENT REGISTRATION FORM

Client Name: First Middle Last				**Date of Birth & Age:**
Home Address: Apt. No.		**City:**	**State:**	**Zip Code:**
Occupation:		**Marital Status:**		**Gender:**
Email Address:		**Cell Phone:**		**Home Phone:**
Employer:		**Work Address:**		**Work Phone:**
Name of Responsible Party if Not Self: **Relationship to Client:** **Home Address:** Apt. No. **City:** **State:** **Zip Code:** **Home/Cell Phone:** **Work Phone:**				
Doctor:		**Phone:**		**Fax:**
Doctor Address:		**City:**	**State:**	**Zip Code:**

Referred By *check all that apply*:
☐ Meredith Murphy ☐ Anne Butler ☐ Doctor ☐ Friend ☐ Internet ☐ Health Plan ☐ Other write-in

HEALTH INSURANCE INFORMATION

PRIMARY INSURANCE	**Insurance Company Name:**	**ID or Policy #:**		**Group #:**
	Insurance Effective Date:	**Insurance Company Phone #:**		
	Claims Address:	**City:**	**State:**	**Zip Code:**
	Subscriber's Name:	**Date of Birth:**	**Social Security #:**	
	Subscriber's Relationship to Client: ☐ Self ☐ Spouse ☐ Dependent ☐ Other	**Employer of Insured:**		

Do you have any other Insurance? ☐ No ☐ Yes please specify

A message can be left on any of the following:

☐ home phone ☐ cell phone ☐ work phone ☐ email ☐ none

SESSION PURPOSE & GOALS

Please describe the primary reason for your visit:

What would you like to achieve by working together?

Short-term: 1.

2.

Long-term: 1.

2.

Have you worked with a nutritionist/dietitian before? ☐Yes ☐No

If yes, how was your experience:

HEALTH HISTORY

Please list any food allergies or other allergies that you have diagnosed and your reaction(s)?

Please check all medical diagnoses that you may have. Please list below any not listed.

☐ Crohn's Disease	☐Food Allergies	☐Type 2 Diabetes	☐Polycystic Ovarian Syndrome
☐ Ulcerative Colitis	☐Celiac Disease	☐Pre-diabetes	☐Infertility
☐ Diverticulosis	☐Thyroid Disease	☐Heart Disease	☐Anemia
☐ Irritable Bowel Syndrome	☐Eating Disorder	☐High Cholesterol/TG	☐Vitamin D Deficiency
☐ GERD/Reflux	☐Cancer	☐High Blood Pressure	☐Osteoporosis
☐Constipation	☐Sleep Apnea	☐Metabolic Syndrome	☐Failure-to-thrive
☐Diarrhea	☐Migraines	☐Overweight/Obesity	☐Kidney Disease

Other Medical Conditions:

Please list any family history of chronic illness (e.g. diabetes, high cholesterol, heart disease, eating disorder, cancer):

Have you had any surgeries or procedures that I should be aware of (bariatric surgery, gastrointestinal surgery, etc.):
☐No
☐Yes – please describe

Please list any mental health diagnoses I should be aware of (e.g. depression, bipolar, PTSD, OCD):

Please describe any symptoms that you are currently suffering from (brain fog, night sweats, fatigue, etc.)

Please list any recent or abnormal lab values I should be aware of (e.g. A1C, high cholesterol, low vitamin D, low iron); if you have copies of recent lab work please bring them, you can also ask your doctor to fax them to my office, 1-888-979-9268.

For women, please describe your menstrual cycle:

Age of first menstrual cycle:
Regular Periods? ☐Yes ☐No Describe:
Menopause? ☐Yes ☐No

Weight History
Please describe your weight history (leave blank if it feels uncomfortable and we can discuss together):

Current Weight:
Highest Weight/When: Lowest Weight/When:
Do you weigh yourself? ☐Yes ☐No If yes, how often?

MEDICATIONS & SUPPLEMENTS

Please list the name and dosage of current medications, prescription and over-the-counter medications that are regularly taken:

Medication Name	Dosage	Frequency (how often ?)

Please list the brand and dosage of any Vitamin/Mineral or Herbal Supplements you take (please bring the bottles to your visit):

Supplement Name/Brand	Dosage	Frequency (how often?)

LIFESTYLE HISTORY

Please describe your weekly activity level (type, duration, frequency):

Describe your tobacco smoking history?

☐Never Smoked ☐Smoke packs/day ☐ Quit date quit ☐Regular Second Hand Smoke Exposure

On a scale of 1-to-10, how high is your current stress level?

Do you have a good support system? ☐Yes ☐No

What do you do for relaxation/pleasure/fun?

NUTRITION HISTORY (we will discuss your current eating pattern and intake in detail during the session)

Are there any foods that you avoid or choose not to eat for personal or religious or cultural factors?

☐Yes ☐No If yes, please describe: _____

_____

_____

Do you have any of the following gastrointestinal problems related to eating?

☐Nausea ☐Constipation ☐Diarrhea ☐Vomiting
☐Heartburn ☐Difficulty Chewing ☐Difficulty Swallowing ☐ Gas
☐Other, describe: _____

Who usually does the grocery shopping and which stores?

_____

_____

Who does the cooking?

_____

_____

How often do you eat out and what kind of restaurants?

_____

_____

Please describe your alcohol intake (type, amount and frequency such as per/day, per/week):

_____

_____

Please list any other information you would like me to know:

_____

_____

_____