Nutrition Medical History Form

Today's Date:	Last Name:	First Name:	Middle Init.	Gender
DOB:	Parent/Guardian (if minor):	PCP/Pediatrician:		
Home Address	Apt #	City	State	Zip Code
Home Telephone #	Cell Phone #	Email Address:		
Emergency Contact Name and Relationship:		Telephone #		
Who referred you/how did you hear about us?				

Height: _____ Weight: _____

Have you gained or lost more than 10 lbs in the last 6 months? Yes ◯ No ◯

If yes, how:

_____

What are your nutritional concerns?

_____

What are your goals?

_____

Describe your current exercise schedule and program?

_____

Have you worked with a Registered Dietitian in the past? Yes ◯ No ◯

If yes, when:

_____

Medical History (check all that apply)

☐ Eating Disorder	☐ Diabetes	☐ Pre-Diabetes	☐ PCOS
☐ High Cholesterol	☐ Insulin Resistance	☐ Hypothyroidism	☐ GI Disorder
☐ High Blood Pressure	☐ Heart Disease	☐ Hyperthyroidism	

Food Allergies (please list): _____

Medications: _____

To the best of my knowledge and belief, the information I have given is complete and true.

Client Signature: _____ Date: _____

Parent/Guardian Signature (if minor): _____ Date: _____

RD Signature: _____ Date: _____