Name _____DOB_____

Do you currently see a medical doctor for any reason? _____ What for? _____

Prescription and over the counter drugs you regularly take: _____

Nutritional supplements you regularly take: _____

Surgeries/organs removed: _____

Do you currently have problems with any of the following:

Allergies _____	ADHD_____	Cancer _____
Intolerances_____	Dizzy Spells _____	Joint aches _____
Leg cramps _____	Digestive problems _____	Fluid retention _____
Constipation _____	Nervous tension _____	Skin problems _____
High blood pressure_____	Diabetes _____	Mood swings _____
Depression _____	Breathing problems _____	Heart problems _____
Kidney problems _____	Osteoporosis _____	High Cholesterol _____
Hyperthyroidism _____	Menstrual cramps _____	Headaches _____
Hypothyroidism _____	PMS/Menopause _____	

Please provide 1 day of food intake include the food/beverage consumed, amount, and calorie estimate to the initial visit.

Breakfast:

Snack:

Lunch:

Snack:

Dinner:

Snack:

Please have 3 goals in mind to discuss (i.e., weight loss, sports training, lowering cholesterol, preventing diabetes, etc.).

1.

2.

3.

Signature _____ Date _____

FHN
Food Health & Nutrition

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