Nutrition Works Client Health History

Demographics and coordination of care:		
Your name:	Date of birth:	Today's date:
Primary care provider name:	Gastroenterology specialist name:	Other specialist name:

Circle or write in your medical conditions, significant history and nutrition concerns:

Gastric reflux (GERD)	Vitamin deficiency	Heart disease
Celiac disease	Anemia	High blood pressure
Diverticular disease	Unintentional weight loss	Atrial fibrillation
Constipation	Underweight	Stroke
Diarrhea	Overweight or obesity	Pre-diabetes
Gallbladder disease	Osteopenia	Diabetes
Ulcerative Colitis	Osteoporosis	PCOS
Crohn's disease	Eating disorder	Hypothyroidism
Fatty liver disease	Anxiety	High triglycerides
Ileostomy	Depression	High cholesterol
Irritable bowel syndrome (IBS)	Insomnia	Kidney disease
Small intestinal bacterial overgrowth	Kidney stones	Cancer
Lactose intolerance	Endometriosis	Migraine headaches
Food sensitivity or intolerance		
Food allergy		
Other:		

Which of the above concerns is the **main reason** for your visit? If concerns related to overweight or obesity are your top priority, and you would like to reschedule with one of our weight management experts, please phone our office at 207-772-6279. Thank you.

List gastrointestinal or abdominal surgeries, including date:

Significant family history:

Weight history; please circle yes or no as needed:		
Height:	Current weight:	
Have you gained weight lately? Yes No Have you lost weight lately? Yes No	How much? Over what time period?	Was recent loss/gain intentional? Yes No
Your preferred weight:	Are you looking for assistance with working toward a healthy body weight? Yes No	Any concerns about disordered eating behaviors or thoughts? Yes No

--OVER--

Exercise, health, and eating habits:	
Has your doctor placed any limitations on your ability to exercise?	How many times per week do you exercise? Total hours per week?
What exercises or activities do you perform?	How many hours a night do you sleep?
How do you cope with stress?	Occupation and usual work hours?
Who plans the meals at home?	Who does the shopping? How often? Where?
Who does the cooking at home?	How much water do you drink?
What type of diet has your doctor recommended?	Do you smoke? Yes No Former smoker How many years ago did you quit?
Number of times per week eating takeout, restaurant, cafeteria or heat-and-serve food? Where/where from?	Do you follow a particular diet or food lifestyle? For how long? Has it helped with your gastrointestinal problems?

Please list all **prescription or over-the counter medications, dietary supplements and herbal preparation**s that you are currently taking. You can attach a separate list if you have one from medical records, as long as it is up-to-date.

Name, brand and strength, if applicable	Prescribing/dosing details	Date started	Prescriber
Examples: Multivitamin, Vitafusion	1 gummy daily	2005	self
Calcium carbonate, Nature Made 300mg	1 tablet, twice daily	8/2017	Dr. XYZ

--OVER--

- Record all foods and beverages consumed for four days and nights before your visit.
- Describe the type of food, brand, and how it was prepared.
- List the amount consumed using cup, ounces, inches, etc.
- Don't forget snacks and beverages, and extras such as cream, sugar, margarine or mayo.

Circle type of day: Workday Non-Workday Holiday Prep: Write in where the food was prepared; Home-prepared (H), Restaurant (R), Take-out (TO) or Convenience Food (C)			Circle type of day: Workday Non-Workday Holiday Prep: Write in where the food was prepared; Home-prepared (H), Restaurant (R), Take-out (TO) or Convenience Food (C)		
Time	Prep	Food Amount	Time	Prep	Food Amount

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Patient Registration
Please fill out and bring to your first visit.

(Please Print)

PATIENT INFORMATION					
Patient's Last Name: First: Middle:					
Street address:			Parent's Name (Minors):		
P.O. Box:	City:		State:	ZIP Code:	
Home Phone:	Work Phone:	Cell Phone:	Birth date: / /		Sex: ❑ M ❑ F
Occupation:	Email Address:		Can we send information about nutrition or cooking classes to your email address? ❑ Yes ❑ No		
Primary Care Physician:	Name, address and phone # of practice:				
Specialist (if applicable):	Name, address and phone # of practice:				

BILLING AND INSURANCE INFORMATION		
Insurance Company Name:	ID or Policy Number:	Group/Code:
Subscriber's Name:	Subscriber's Employer:	Subscriber's Birth Date / /
Patient's relationship to subscriber:	Are nutrition services coved by your insurance?	How many visits?
Do you have any other insurance? ❑ Yes ❑ No		