



For office use only	
Ht: _____	Wt: _____
Shoes / No Shoes _____	
BF%: _____	Hydration% _____

Patient Information Form: Metabolism & Nutrition

Name _____ Date of Birth _____ Today's Date _____

Address _____ Zip Code _____

Phone # _____ Email _____

Who referred you to us? _____ Who is your Primary Doctor? _____

Can we communicate our nutrition and exercise plan to your doctor(s)? Y / N

1. What is your primary goal for being here today?

2. Do you currently or have you had problems with any of the following?

- | | | | |
|--------------------------------|-------------|--------------------------------|-------------|
| a. Gallbladder | Y / N _____ | k. Disordered Eating | Y / N _____ |
| b. Stomach Reflux | Y / N _____ | l. Thyroid | Y / N _____ |
| c. Diabetes / High Blood Sugar | Y / N _____ | m. Food Allergies/Intolerances | Y / N _____ |
| d. Heart Disease | Y / N _____ | <i>Please list:</i> _____ | |
| e. Joint Pain | Y / N _____ | n. Lactose Intolerance | Y / N _____ |
| f. Back Pain | Y / N _____ | o. Other | Y / N _____ |
| g. High Blood Pressure | Y / N _____ | <i>Please list:</i> _____ | |
| h. High Cholesterol | Y / N _____ | | |
| i. Depression | Y / N _____ | | |
| j. Osteopenia or Osteoporosis | Y / N _____ | | |

3. If You Are Here For a Cancer-Related Issue, Please Complete The Following (if not, skip to the next section):

Diagnosis: _____

Date of diagnosis: _____

Pre-diagnosis weight: _____

Name of oncologist or facility where you are getting treatment: _____

Check any that apply (skip all that don't apply)

Does your current or recent treatment include:

- | | |
|--------------------|-----------------------------------|
| _____ Radiation | |
| _____ Surgery | Name of procedure and date: _____ |
| _____ Chemotherapy | Name(s): _____ |

Please list any gastrointestinal side effects you are experiencing from cancer treatment.

(For example, nausea, diarrhea, mouth sores, etc?)

Do you or have you had: *(Check all that apply)*

- | | | |
|---------------------|-----------------|------------------------|
| feeding tube: | _____ currently | _____ in past 3 months |
| IV nutrition (TPN): | _____ currently | _____ in past 3 months |

4. Do you want to lose weight? Y/ N gain weight? Y/ N If yes, how much? _____
 If yes to either, please answer the following questions:
 a. What is the *most* you have ever weighed? _____ At what age? _____
 b. What is the *least* you have ever weighed as an adult? _____ At what age? _____
 c. What is the most amount of weight you have ever lost during one attempt? _____
 How long did it take? _____ How long ago was this? _____

5. What diet plan(s) have you tried?

6. Please list any current medications:

7. Please list any supplements:

8. Do you like to exercise? Y / N
 If yes, what do you do? _____ How many times per week? _____

Please use the calendar below if you have a set regimen currently.

Mon	Tues	Wed	Thurs	Fri	Sat	Sun

9. How many meals and snacks per day do you eat? _____meals _____snacks

Please give examples of your meals and snacks in the table below.

	Breakfast	snack	Lunch	snack	Dinner	snack
Time						
Meal						

10. Do you have a favorite evening snack?

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RMR _____ kcal/day _____ G: V: F: D: M: fat: Disc: Exerc: Rate of ▲: