Boulder NUTRITION and EXERCISE

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

Patient Information Form: Metabolism & Nutrition

Name _____ Date of Birth _____ Today's Date _____

Address _____ Zip Code _____

Phone # _____ Email _____

Can we send you emails with information? Y / N

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

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

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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_____	_____	
c. Diabetes / High Blood Sugar	Y / N_____	l. Thyroid	Y / N
d. Heart Disease	Y / N_____	m. Food Allergies/Intolerances	Y / N
e. Joint Pain	Y / N_____	*Please list:* _____	
f. Back Pain	Y / N_____	_____	
g. High Blood Pressure	Y / N_____	n. Lactose Intolerance	Y / N
h. High Cholesterol	Y / N_____	o. Other	Y / N
i. Depression	Y / N_____	*Please list:* _____	
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 ▲:

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