

Patient Initial Assessment for Nutrition Counseling



**RICHMOND
Family Medicine**

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Appointment Scheduling/Cancellations: (802) 434-4123

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Date:

Name			
Date of Birth	Age:	Gender:	M F
Address			
City, State, Zip code			
Phone	Cell:	Home:	Work:
Email			
Best way to contact?	Email	Phone	Leave a message? Y N
Primary Physician	Name:	Email:	City: Phone:
Other Pertinent Provider	Name:	Email:	City: Phone:
Referred by			

Complaints/Concerns

What do you hope to achieve in your visit?

List your three main health/nutrition concerns:

- 1)
- 2)
- 3)

When was the last time you felt well?

Did something trigger your change in health?

What makes you feel better?

What makes you feel worse?

Allergy Information

List Food Allergies	
List non-food allergies (Meds/supplements)	
List environmental allergies	
What are the symptoms?	

Family History

Please note any family history of the following diseases: heart disease, cancer, stroke, high blood pressure, overweight, lung disease, diabetes, mental illness or addiction

Family Member:	Health Condition:
Family Member:	Health Condition:
Family Member:	Health Condition:
Family Member:	Health Condition:

Medical History

Please check health conditions that your doctor has diagnosed and provide the date of onset.

Gastrointestinal

- Irritable Bowel Syndrome
- Inflammatory Bowel Disease
- Chron's Disease
- Ulcerative Colitis
- Celiac Disease
- Gastric or Peptic Ulcer Disease
- GERD, reflux/heartburn
- Hepatitis C or Liver Disease

Other:

Respiratory

- Asthma
- Chronic Sinusitis
- Pneumonia
- Sleep Apnea
- Emphysema

Other:

Cardiovascular

- Heart Disease
- Stroke
- Elevated Cholesterol
- Irregular Heart Rate
- High Blood Pressure
- Mitral Valve Prolapse

Other:

Inflammatory/autoimmune

- Chronic Fatigue Immune
- Deficiency Syndrome
- Autoimmune Disease
- Rheumatoid Arthritis
- Lupus
- Poor Immune Function
- Severe Infections Diseases
- Herpes
- Gout

Other:

Musculoskeletal/Pain

- Osteoarthritis
- Chronic pain
- Fibromyalgia
- Migraines

Other:

Cancer:

Please describe type and treatment:

Neurological/Brain

- Depression
- Anxiety
- Autism
- Seizures
- Bipolar Disorder
- ADD/ADHD
- Multiple Sclerosis

Other:

Metabolic/Endocrine

- Diabetes (Type 1 or 2)
- Metabolic Syndrome
- Hypoglycemia
- Hypothyroidism
- Hyperthyroidism
- Polycystic Ovarian Syndrome
- Infertility

Other:

Dermatological

- Eczema
- Psoriasis
- Acne
- Rosacea

Urinary/Gynecological

- Kidney Stones
- Urinary (UTI's)
- Yeast infection

Medications and Supplements

Please list all prescription medications and supplements, herbs/botanicals you are currently taking.

Medication Name	Dose	Frequency	Reason
Supplement Name	Dose	Frequency	Reason

Have you had prolonged or regular use of NSAIDS (Advil, Aleve, Motrin, Aspirin)? Yes No

Have you had prolonged use of Tylenol? Yes No

Have you had prolonged use of acid-blocking drugs (Zantac, etc)? Yes No

Frequent antibiotics >3X per year? Yes No Long term antibiotics? Yes No

Nutrition History

Have you ever had a nutrition consultation? Yes No
Have you made any changes in your eating habits because of your health? Yes No (describe below)
Do you currently follow a special diet or nutritional program? Yes No (describe below)
Do you avoid any particular foods? Yes No (describe below)

Height:	Weight:	Desired weight:
Usual weight range:		Waist circumference:
Have you had any recent history of weight loss or gain? (please describe)		
Do you have (or had) an eating disorder? Yes No (describe below)		
How many meals per day do you eat?		How many snacks?
How many meals do you eat out per week?		
Do you have any adverse food reactions (allergies or intolerances)? Yes No (describe below)		
Do you drink alcohol? Yes No How many drinks per week?		
Do you drink coffee or other caffeinated beverages? Yes No How many drinks per day?		

Do you use any artificial sweeteners? Yes No (which ones?)
Favorite foods:

Check all the factors that apply to your current lifestyle and eating habits:

- | | |
|---|--|
| <input type="checkbox"/> Fast Eater | <input type="checkbox"/> Struggle with eating issues |
| <input type="checkbox"/> Erratic eating patterns | <input type="checkbox"/> Emotional eater |
| <input type="checkbox"/> Eat too much/overeats | <input type="checkbox"/> Eat fast food frequently |
| <input type="checkbox"/> Late night eating | <input type="checkbox"/> Poor snack choices |
| <input type="checkbox"/> Rely on convenience items | <input type="checkbox"/> Do not plan meals or menus |
| <input type="checkbox"/> Love to eat | <input type="checkbox"/> Eat because I have to |
| <input type="checkbox"/> Love to cook | <input type="checkbox"/> Negative relationship with food |
| <input type="checkbox"/> Family members have different tastes | <input type="checkbox"/> Dislike healthy food |
| <input type="checkbox"/> Live or often eat alone | <input type="checkbox"/> Travel Frequently |
| <input type="checkbox"/> Time constraints | <input type="checkbox"/> Confused about food/nutrition |

Lifestyle Information

List the exercise that you participate in weekly.

Activity	Type/Intensity (low-high)	# of days per week	Duration (minutes)
Stretching/yoga			
Cardio/Aerobics			
Strength Training			
Sports or Leisure			

Note any problems that limit your physical activity.

Do you smoke? Yes No

Daily Stressors: (rate on a scale of 1 (low) to 10 (high)

Work ____ Family ____ Social ____ Finances ____ Health ____ Other: _____

Average number of hours of sleep per night during the week:

Average number of hours of sleep per night during the weekend:

Trouble falling asleep? Yes No

Readiness Assessment

On a scale of 1 (not willing) to 5 (very willing) answer the following questions.

In order to improve your health how willing are you to:

Significantly modify your diet	
Take nutritional supplements each day	
Keep a record of everything you eat each day	
Modify your lifestyle (sleep, work, exercise)	
Practice a relaxation technique	
Engage in regular exercise/physical activity	
Have periodic lab tests to assess your progress	