TINA SHIVER, RD, IFMCP

Client Information

Name_____ Date_____

Address _____
_____
_____

Home Phone _____ okay to leave message? _____
Cell Phone _____ okay to leave message? _____
Work Phone _____ okay to leave message? _____
Email Address _____

Emergency Contact _____ phone _____

Date of Birth _____ Age _____ Place of Birth _____
Occupation _____ How long? _____

Primary Care Physician _____
Referred by _____

Insurance Information

If this visit is covered by insurance (Cigna), please fill in the information below.

Insurance Company _____
Policy/Group Number _____
Individual ID Number _____

Copay $_____

What are your goals in working with a dietitian?

_____
_____
_____
_____

Family History

Father:	Alive	Deceased	Cause of death? _____
Mother:	Alive	Deceased	Cause of death? _____
Brothers:	# Alive	# Deceased	Cause of death? _____
Sisters:	# Alive	# Deceased	Cause of death? _____
Children:	# Alive	# Deceased	Cause of death? _____

Current/Past Medical Information

Height: _____
Weight: _____
Ideal body weight: _____

Please list and rank any current ongoing problems by priority and fill in the other categories as completely as possible.

Describe Problem	Mild/ Moderate/ Severe	Treatment Approach	Success
(Example: Post nasal drip)	(Moderate)	(Elimination diet)	(Moderate)
a.			
b.			
c.			

Do you have any pets or farm animals? Do they live indoors or out?

_____
_____

Have you ever lived or traveled outside of the United States? If so, where and when?

_____

_____

Have you or your family recently experienced any major life changes? If so, please explain.

_____

_____

Have you ever experienced any major losses in life? If so, please explain.

_____

_____

Past medical or surgery history:

	ILLNESSES	WHEN	COMMENTS
a.	Anemia		
b.	Arthritis		
c.	Asthma		
d.	Bronchitis		
e.	Cancer		
f.	Chronic Fatigue Syndrome		
g.	Crohn's Disease or Ulcerative Colitis		
h.	Diabetes		
i.	Emphysema		
j.	Epilepsy, convulsions, or seizures		
k.	Gallstones		
l.	Gout		
	ILLNESSES	**WHEN**	**COMMENTS**
m.	Heart attack/Angina		
n.	Heart failure		
o.	Hepatitis		
p.	High blood fats (cholesterol, triglycerides)		
q.	High blood pressure (hypertension)		
r.	Irritable bowel		
s.	Kidney stones		
t.	Mononucleosis		
u.	Pneumonia		
v.	Rheumatic fever		
w.	Sinusitis		
x.	Sleep apnea		

y.	Stroke		
z.	Thyroid disease		
aa.	Other (describe)		
	INJURIES	**WHEN**	**COMMENTS**
ab.	Back injury		
ac.	Broken (describe)		
ad.	Head injury		
ae.	Neck injury		
af.	Other (describe)		
	DIAGNOSTIC STUDIES	**WHEN**	**COMMENTS**
ag.	Barium Enema		
ah.	Bone Scan		
ai.	CAT Scan of Abdomen		
aj.	CAT Scan of Brain		
ak.	CAT Scan of Spine		
al.	Chest X---ray		
am.	Colonoscopy		
an.	EKG		
ao.	Liver scan		
ap.	Neck X---ray		
aq.	NMR/MRI		
ar.	Sigmoidoscopy		
as.	Upper GI Series		
at.	Other (describe)		
	OPERATIONS	**WHEN**	**COMMENTS**
au.	Appendectomy		
av.	Dental Surgery		
aw.	Gall Bladder		
ax.	Hernia		
ay.	Hysterectomy		
az.	Tonsillectomy		
ba.	Other (describe)		
bb.	Other (describe)		

Have you ever been hospitalized? If so, when, and for what reason?

_____
_____
_____

How often have you taken antibiotics?
Infancy/childhood _____ Teen _____ Adulthood _____

How often have you taken oral steroids (e.g., Cortisone, Prednisone, etc.)?
Infancy/childhood _____ Teen _____ Adulthood _____

Are you currently taking any prescription drugs?

Medication Name	Date Started	Dosage
1.		
2.		
3.		
4.		
5.		

Please list any vitamins, minerals or other nutritional supplements that you are currently taking. Indicate whether mg or IU and the form (e.g., calcium carbonate vs. calcium lactate), when possible.

_____
_____
_____
_____
_____

Childhood
Were you a full---term baby?

Were you breast or bottle---fed?

As a child did you eat a lot of sugar and/or candy?

As a child, were there any foods that you had to avoid because they gave you symptoms? If so, please list, including any symptoms you may have had.

_____
_____

Current Information
Are you on any kind of special diet? If so, please list and explain.

_____
_____

Do you have any symptoms <u>immediately after</u> eating, such as belching, bloating, sneezing, hives, etc.? If so, please explain.

_____

Do you feel you have any <u>delayed</u> symptoms after eating certain foods (symptoms may not be evident for 24 hours or more), such as fatigue, muscle aches, sinus congestion, etc.?

_____
_____

Do you feel much <u>worse</u> when you eat a lot of:
____ high fat foods ____ refined sugar (junk food)____ high protein food
____ fried food____ high carbohydrate foods ____ 1 or 2 alcoholic drinks

Do you feel much <u>better</u> when you eat a lot of:
____ high fat foods ____ refined sugar (junk food)
____ high protein foods ____ fried foods
____ high carbohydrate foods
(breads, pastas, potatoes)

Does skipping a meal greatly affect your symptoms? ____ yes ____ no

Have you ever had a food that you craved or really "binged" on over a period of time? If yes, what foods?

_____

Do you have an aversion to certain foods? If yes, what foods?

_____
_____
_____
_____
_____

Please fill in with checkmarks below information about your bowel movements.

Frequency

More than 3x/day _____
1---3x/day _____
4---6x/week _____
2---3x/week _____
1 or fewer x/week _____

Color

Medium dark brown consistency _____
Very dark or black _____
Greenish color _____
Blood is visible _____
Varies a lot _____
Dark brown consistently _____

Consistency

Soft and well---formed _____
Often float _____
Difficult to pass _____
Diarrhea _____
Thin, long or narrow _____
Greasy, shiny appearance _____
Yellow, light brown _____

Small and hard _____
Loose but not watery _____
Alternating between hard and loose/watery _____

Intestinal gas

Daily _____
Occasionally _____
Little odor _____

Excessive _____
Present with pain _____
Foul---smelling odor _____

Have you ever used alcohol? Yes _____ No _____

If yes, how often do you now drink alcohol?

_____ No longer drinking alcohol
_____ Average 1---3 drinks per week
_____ Average 4---6 drinks per week
_____ Average 7---10 drinks per week
_____ Average more than 10 drinks per week

Have you ever had a problem with alcohol? Yes____ No____

If yes, please indicate time period (month/year): from_____ to _____

Have you ever used recreational drugs? Yes____ No_____

If yes, please indicate time period (month/year): from_____ to _____

Have you ever used tobacco? Yes____ No____

If yes, number of years as a nicotine user: _____ Amount per day: _____

Year quit: _____

What type of nicotine have you used?

_____ Cigarettes _____ Smokeless
_____ Cigar _____ Pipe
_____ Patch/gum

Are you exposed to second---hand smoke regularly? Yes ____ No ____
Do you have any mercury amalgam fillings? Yes ____ No ____
Do you have any artificial joints or implants? Yes ____ No ____
Do you feel worse at certain times of the year? If yes, when?
____ spring ____ fall ____ summer ____ winter

Have you, to your knowledge, been exposed to any toxic metals in your job or at home? If yes, which one(s)?
____ lead ____ cadmium
____ arsenic ____ mercury
____ aluminum other: _____

Do odors affect you? Yes ____ No ____

How do you feel things are going for you at this time?

	Very Well	Fair	Poorly	Very Poorly	Does not apply
a. At school					
b. In your job					
c. In your social life					
d. With close friends					
e. With sex					

Have you ever had psychotherapy or counseling? Yes ____ No ____
Currently? _____ Previously? _____ If previously, from: _____ to _____
What kind?_____
Comments:
_____

Do you exercise regularly? Yes ____ No ____
If yes, how many times per week?
____ 1x ____ 2x ____ 3x ____ 4x or more

When you exercise, how long is each session?
___ ≤15 minutes ___16---30 minutes ___ 31---45 minutes ___ >45 minutes

What type or exercise is it?
____ jogging/walking____ tennis____ water sports____ basketball
____ home aerobics
other: _____

For women only:

Have you ever used birth control pills? Yes ____ No ____

Are you taking the pill now? Yes ____ No ____

Did taking the pill agree with you? Yes ____ No ____

In the second half or your cycle, do you have symptoms of breast tenderness, water retention or irritability (PMS)? Yes ____ No ____

Are you in menopause? Yes ____ No ____

If yes, age at your last period: _____

Do you take: ____ Estrogen ____ Ogen ____ Estrace

____ Premarin ____ Progesterone ____ Provera

other: _____

How long have you been on hormone replacement therapy (if applicable)?

_____

Payment and Cancellation Agreement:

I understand that payment is expected at the time of my visit and agree to make full payment at that time, unless my visit is expected to be covered by my insurance company (Cigna).

I understand that when I schedule an appointment I am agreeing to appear at that scheduled time, and if I do not or if I reschedule **without twenty---four hour notice** I will be charged a cancellation fee of at least $50. **By signing below, I am agreeing to these scheduling/cancellation fee terms**.

Patient signature: _____ Date: _____