Artemis in the City, LLC
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Nutrition Consultation Intake Form

Please write or print clearly

PATIENT INFORMATION:

Date: ....

Name (First / MI / Last): ....

Address Line 1: ....

Address Line 2: ....

City: .... State: .... Zip Code: ....

Telephone – Work: .... Home: .... Mobile: ....

Email address: .... How often do you check email? ....

Relationships status: .... Children? ....

Occupation: .... Hours of work per week: ....

Sex: .... Age: .... Date of Birth: .... Place of Birth: ....

Ethnic Background: ....

Height: .... Frame Size (S,M,L): ....

Current weight: .... Weight six months ago: .... One year ago: ....

Would you like your weight to be different? .... Desired Weight: ....

Have you seen a nutritionist before? ....

Referred by (physician, friend, other)? ....

MEDICAL HISTORY:

Date of Last Physical Exam: .... Date of Last Full Bloodwork: .... Blood Type (A, AB, B, O): ....

List serious illnesses/ hospitalizations/ injuries/ infections / operations / diagnostic (indicate year)? ....

Are there any doctors, healers, helpers or therapies with which you are involved? Please list: ....

MEDICAL HISTORY:

Please note with an “x” if you have been diagnosed with any of the following. List the year you were diagnosed or experienced the symptoms and also describe/specify where necessary.

Disease / Illness / Symptom	Current:	Past:	Describe/Specify
Acne			
AIDs or HIV+			
Alcohol or Drug Addiction (specify)			
Allergies (specify)			
Alzheimer’s Disease /Vascular Dementia/ Memory Issues (specify)			
Anemia			
Anxiety or Panic Attacks (specify)			
Arthritis (osteoarthritis or rheumatoid) (specify)			
Asthma / Breathing Issues (specify)			
Autism			
Autoimmune condition (specify)			
Bad Breath			
Bleeding Tendency (specify)			
Blood Transfusions			
Brain Fog			
Bronchitis			
Cancer (specify type)			
Chickenpox / Shingles (specify)			
Chronic Fatigue Syndrome			
Cold Hands and Feet			
Cold Sores / Herpes Virus			
Dental or Mouth Issues (specify)			
Dehydration			
Depression/Mood Disorders/Bipolar (specify)			
Diabetes (specify type)			
Digestive Disorders / Gastrointestinal Disorders (specify)			
Diarrhea / Constipation (specify)			
Dry itchy skin, rashes, hives, dermatitis (specify)			
Eating Disorder (specify)			
Eczema or Psoriasis (specify)			
Emphysema			
Exposure to Environmental Toxins (specify)			
Epilepsy, convulsions or seizures (specify)			
Eye Disease / Glaucoma / Vision Issues / Dry (specify)			
Fibromyalgia			
Food Allergies or Sensitivities			
Frequent Illness			
Fungal Infection:Candida/Yeast, Athlete’s Foot, Ringworm(specify)			
Gallbladder Disease / Gallstones (specify type)			
Gas / Bloating / Belching			
Genital Issues (specify)			
Gout			
Hairloss			
Heart Attack / Angina			
Heartburn / Acid Reflux (specify)			
Heart Disease / Cardio Vascular Disease (specify)			
Hemorrhoids			
Hepatitis			
Hernia			
High Blood Fats (cholesterol, triglycerides)			

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Disease / Illness / Symptom	Current:	Past:	Describe/Specify
High Blood Pressure (hypertension)			
Hyperactivity			
Hypoglycemia (low blood sugar)			
Intestinal Disease (specify)			
Inflammatory Bowel Disease (Crohn's or Ulcerative Colitis)			
Infertility			
Irritable Bowel Syndrome (IBS)			
Kidney Disease / Failure or Kidney Stones (specify)			
Lung Disease (specify)			
Liver Disease			
Low Libido (Sex Drive)			
Measles			
Mental Health Issues (specify)			
Migraine Headaches			
Mitral Valve Prolapse			
Mononucleosis (Epstein Barr Virus)			
Multiple Sclerosis			
Muscle Cramps			
Muscular Dystrophy			
Mumps			
Nausea			
Neuropathy			
Numbness or Tingling (specify)			
Obesity			
Osteoporosis			
Pacemaker or other Medical Device (specify)			
Pain / Inflammation (specify)			
Parasitic Worms			
Parkinson's Disease			
PMS			
Polycystic Ovarian Syndrome (PCOS)			
Pneumonia			
Prostate Problems			
Restless Leg Syndrome			
Ringing in Ears			
Sexually Transmitted Disease (Herpes, HPV, Other) (specify)			
Sinus Issues			
Sleep Disorder / Apnea / Insomnia (specify)			
Stroke			
Thyroid Disease (specify)			
Tuberculosis			
Ulcers (specify)			
Urinary Issues (specify)			
Vomiting			
Weight-loss / Underweight			
Other:			

SLEEP:

Do you sleep well? ____________ Do you wake up at night? ____________ What times? ____________

To urinate? ____________ What time do you generally get up in the morning? ____________

What time do you go to sleep? ____________ How many hours of sleep? ____________

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BOWEL MOVEMENT:

Constipation/Diarrhea? ....

Number of times? .... per day? .... per week? ....

Describe Consistency (Hard, Loose, Oily, Watery, Smooth Formed, Other): ....

Describe Color (Light Brown, Medium Brown, Dark Brown, Other): ....

Do BMs float or sink? .... Are BMs hard to pass? ....

WOMEN:

Are your periods regular? .... How many days is your flow? .... How frequent? ....

Painful or symptomatic? .... Please explain: ....

Are you pregnant? .... Fertility Issues? .... Menopause? ....

Breast Issues/Fibroids? .... Ovarian Cysts/Fibroids? .... Hormone Issues? ....

Additional (Itching, Dryness, Discharge, Other): ....

Taking Birth Control Medication or Hormone Replacement or have taken in the past? ....

ALLERGIES / SENSITIVITIES:

	Allergies (Severe/Life Threatening):	Sensitivities (Mild to Moderate):
Drugs:		
Foods:		
Environmental Sources:		
Other:		

Have had allergy testing? .... Would like allergy testing? ....

FAMILY HISTORY:
Describe the health of your family members (include weight, cancer, heart disease, diabetes, high blood pressure, high cholesterol, genetic disorders and other):

Mother	
Father	
Siblings	
Grandparents	
Aunts / Uncles Cousins	
Children	

MEDICATIONS / SUPPLEMENTS:
Do you take any vitamins or medications? If so, which? ....

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NUTRITION & LIFESTYLE:

What role does exercise play in your life?

Do you drink coffee, alcohol, smoke cigarettes, or have any major addictions?

What percentage of your food is home cooked? Where do you get the rest from?

How do you feel about food, cooking and shopping?

Any dietary restrictions (religious, vegan, vegetarian, kosher, gluten-free)?

What are your top concerns?

Nutrition and health goals?

What foods did you eat often as a child?

Breakfast	Lunch	Dinner	Snacks	Liquids

What's your food like these days? List what you consumed over the last 24 hours.

Breakfast	Lunch	Dinner	Snacks	Liquids

PLAN OF ACTION NOTES: (to be completed by nutritionist)

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