AZNutritionCenter
MASTER HEALTHY LIVING

NEW CLIENT INFORMATION

Today's Date_____

PERSONAL INFORMATION

Name:_____Age:_____ Date of Birth:_____

Marital Status S__ M__ D__ W__ Other_____

Mailing Address:_____ City: _____ State: ____ Zip: _____

Home Phone: (_____) _____ Cell Phone: (_____) _____ E-mail:_____

Occupation: _____ Employer/School: _____

Work Phone: (_____) _____ Work Status: Full-Time __ Part-Time__ Seasonal__ Other _____

In case of an Emergency – Contact: _____Relationship: _____

Home Phone: (_____) _____ Cell Phone: (_____) _____

Most of our patients are referred to us by a caring family or friend. Whom may we thank for referring you to our office? Or how did you hear about us? _____

General Information:

Height:_____ Weight: _____ Recent Weight Loss __ / Gain __? Amount? _____ lbs.

Reason/method for weight loss/gain: _____ Number of Bowel Movements/Day: _____

Difficulty Falling asleep? Y__ N__ Difficulty Staying Asleep Y__ N__ Tired after full night's sleep? Y__ N__

Lightheaded/Irritable When Hungry? Y__ N__ Crave sugar/salt? Y__ N__ Fatigue after meals? Y__ N__

Need coffee/sweets 3-4pm? Y__ N__ Do you eat Breakfast? Y__ N__ Do you eat snacks b/t meals Y__ N__

Usual Breakfast:_____
Usual Lunch: _____
Usual Dinner:_____
Usual Snack:_____

Do you have any dietary restrictions? Food allergies? Y__ N__ Please explain: (Paleo, vegetarian, gluten, dairy intolerance, Kosher, etc.)_____
_____

CLIENT NAME: _____

Women Only:

Is there any chance you might be pregnant? Y__ N__ Date of last Menstrual cycle: _____

Are you experiencing perimenopause? Y__ N__ Reached Menopause? Y__ N__

Are you experiencing symptoms? Y__ N__ Comments: _____

Do you currently, or have you used any of the following? (Please circle all that apply): Birth Control Pills, Hormone Replacement Therapy, Hormone IUD, Copper IUD, Contraceptive Shot (ex. Depo), Vaginal Ring, Contraceptive Patch, Emergency Contraceptive Length of use of each type? _____

Have you ever had an abnormal PAP? Y__ N__Comments:_____

Age of Menarche (periods began): _____ Age of Children (if any): _____

# of pregnancies: _____ # of birth children: _____ # of C-Sections:_____

Health History:

___Alcoholism
___Anemia
___Cancer
___Cold sores
___Deep vein thrombosis
___Depression/Anxiety
___Diabetes

___Eczema/Psoriasis
___Epilepsy
___Goiter
___Gout
___Heart disease
___Hepatitis A/B/C
___Herpes

___High Blood Pressure
___ HIV/AIDS
___ Pleurisy
___ Pneumonia
___ Stroke
___ Tumor(s)
___ Ulcer(s)

Other: _____

Do you wear corrective lenses? Y__ N__ Date of Last check-up/prescription change? _____

Date of most recent physical/annual exam: _____ Did you have blood-work done? Y__N__

Results/Concerns:_____

_____

_____

Serious Illnesses/Hospitalizations/Surgeries: *Please detail (year, reason, outcome)*_____

_____

_____

_____

WORK ACTIVITY:

__Heavy Labor __Light Labor __Mostly Sitting __Mostly Standing __Walking/Moving __Driving

STRESS LEVEL:

__ Very High __ High __Medium __Low

Have you traveled in the last twelve months? Y__ N__

If yes: Where (especially internationally) _____

_____

If you have any concerns or questions you would like to note here, or issues you think might be related to your condition please do not hesitate to discuss any matter with Dr. Rinehart at any time!

_____

_____

_____

_____ _____

Participant Name (Printed) *Participant Signature*

_____

Date

_____ _____

Parent and/or Guardian Printed *Parent and/or Guardian Signature*

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