# Comprehensive Client Profile

Name _____ Date of birth _____ Current date _____

Address _____

Phone Number _____ Email address _____

Preferred contact method: _____ Can we leave a message? _____

Insurance provider name _____ Policy # _____

Group # _____ Whose name is primary on insurance? _____

Date of birth for primary person on insurance _____ Do you have another insurance plan? _____

If yes, please provide same info as above: _____

How did you hear about us? _____

Reason for visit/Major nutrition concern(s) _____

_____

## Health History

Height _____ Current Weight _____

Recent weight gains/losses (past 12 months)? _____ Amount ____ Time frame_____

Medications _____

_____

Supplements (Vitamins/herbals)_____

_____

Food allergies or sensitivities _____

Do you smoke? ____ #per day ____ Do you drink alcohol? ____ Servings per day/per week _____/_____

Please list any ongoing intestinal issues, such as diarrhea, constipation, bloating or excessive gas:

_____

How many hours of sleep do you get on most nights of the week? _____

Any other information you feel we should know about? _____

_____

## Medical History

Check any of the following medical conditions if you have been diagnosed with, or currently have them:

| | | |
|---|---|---|
| ☐ Anemia | ☐ Gallbladder disease/gallstones | ☐ Liver disease _____ |
| ☐ Autoimmune Disorder_____ | ☐ Gastroesophageal Reflux Disease | ☐ Lung disease_____ |
| ☐ Cancer, Type _____ | ☐ Gout | ☐ Osteoporosis/osteopenia |
| ☐ Celiac disease | ☐ Headaches/migraines | ☐ Polycystic Ovarian Syndrome |
| ☐ Crohn's Disease, unspecified | ☐ Heart disease _____ | ☐ Pre-diabetes |

| | | |
|---|---|---|
| ☐ Chronic Kidney Disease, Stage ___ | ☐ High cholesterol | ☐ Sleep apnea |
| ☐ Diabetes, Type ___ | ☐ HIV/AIDS | ☐ Stomach ulcers |
| ☐ Diverticulitis | ☐ Hypertension (High Blood Pressure) | ☐ Stoke |
| ☐ Eating disorder _____ | ☐ IBD (Crohn's or ulcerative colitis) | ☐ Other _____ |
| ☐ Fibromyalgia | ☐ IBS (Irritable Bowel Syndrome) | ☐ Other _____ |

Other Medical Conditions or surgeries? _____

_____

Do you have family history of any of the following? Check any that apply

| | | | | |
|---|---|---|---|---|
| ☐ Cancer | ☐ Diabetes | ☐ Heart disease | ☐ High blood pressure | ☐ High cholesterol |

Other Family medical history _____

Date of last physical _____ Date of last blood test _____

How much time each week do you spend exercising or doing physical activities? _____

What types of physical activites do you enjoy? _____

## Eating information

How many meals and snacks do you eat per day? ____ Meals _____ Snacks

Do you ever skip meals? ____ If yes, please explain _____

Are you on a specific eating plan right now? ____ If yes, describe _____

_____

What eating plans/"diets" have you tried in the past? _____

Do you read nutrition facts labels? _____ If yes, what do you look for on the label?

_____

How often do you eat out weekly and for what meals? _____

Do you ever eat for reasons other than hunger (ie. Boredom, stressed, sad)? ___ If yes, please explain

_____