Patient Medical and Nutrition Information Intake Form

Name:_____ Date:_____

Address:_____City/State/Zipcode:_____

Home Phone Number:_____ Work Phone Number:_____

Cell Phone Number:_____ E-mail Address:_____

Social Security Number:_____ Date of Birth:_____

Occupation:_____

Referral Source:_____ Physician Name:_____

Insurance Provider Name:_____ Policy Number:_____

Have you confirmed coverage with your insurance provider? YES NO

Do you need to be provided with a superbill? YES NO

Battle Born Nutrition does not accept Insurance at this time. You will be responsible for paying for today's visit if you did not confirm coverage prior and request a superbill for your insurance.

Major Nutrition Concern(s):_____

_____

Height:_____ Weight:_____ Usual Weight:_____ Weight at High School Graduation:_____

Lowest/Highest Weight in Last 5 Years: _____ /_____

Medications:_____

_____

Supplements:_____

_____

Do you have a history of intestinal problems, such as bloating, excessive gas, constipation, or diarrhea?:_

_____

Do you take laxatives?:_____

Do you have any food allergies or intolerances?:_____

Do you smoke cigarettes/tobacco products?:_____ If YES, how many years?:____ Number per day:___

Medical History (Illnesses, Surgeries):_____

_____

_____

Family Medical History:_____

_____

_____

Past Diet History:_____

_____

_____

Exercise (How Often/Type/Duration):_____

Eating Information

How many meals and snacks do you eat per day?:_____ Meals _____Snacks

Do you ever skip meals? YES NO If YES, please explain:_____

Do you have times during which you eat uncontrollably? YES NO

If YES, please explain:_____

How many times per week to you dine out?:_____ What types of food do you normally eat when dinning out?:_____

Do you ever eat because you are (Please select if YES):

_____ Lonely _____Bored _____Stressed _____Anxious _____Sad

_____ Depressed _____Happy _____Tired _____Angry

Do you eat (Please select if YES):

_____ In your car _____In bed _____Watching TV _____On the Computer

_____ Reading _____Standing up _____Sitting down _____When not hungry

Which do you enjoy more?

_____ Eating alone _____Eating with others

Do you:

_____ Eat fast _____Eat slow _____Taking big bites

_____ Eat with enjoyment _____Eat without enjoyment

Do you chew your food well before you swallow? YES NO

Do you read Nutrition Fact Labels? YES NO

If YES, what do you look for/at on the label?:_____

Who does the cooking in your house?:_____

Do you know how to cook? YES NO

Who does the grocery shopping?:_____

Do you have enough money for food? YES NO

How many times per week do you eat out?_____ Type of food?:_____