New Client Form

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COUNSELING & WELLNESS

Today's Date: ____/____/_____

Client Name: _____ DOB: ____/____/_____

Phone: _____ May I text you appointment reminders?

E-Mail Address: _____ May I email you practice information?

Current Weight: _____ Height: _____

Medical History: (Please list all past and current medical issues)

_____

_____

_____

_____

_____

_____

_____

Family History:

Condition	Present?	Family Member (s)
Heart Disease		
Cancer		
GI Condition		
Autoimmune Condition		
High Blood Pressure		
High Cholesterol		
Diabetes		
Kidney Disease		
Hypothyroidism		

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Relevant Lab Work:

Lab	Date	Value(s)
A1C		
Comprehensive Metabolic Panel		
Lipid Panel		
Other		

Current Medications: (Including Vitamins and Dietary Supplements)

Medications	Reason	Dose	Prescribed by Healthcare Provider?

FOOD ALLERGIES: _____

FOOD INTOLERANCES: _____

MEDICATION/SUPPLEMENT ALLERGIES: _____

ENVIRONMENTAL: _____

Nutritional Questions/Concerns:

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_____

_____

_____

_____

_____

Personal Diet History:

Have you changed your eating habits for a health reason?	
Are you currently following a particular eating pattern or nutrition plan?	
Do you avoid any particular foods?	
What is your favorite meal?	
Do you cook?	
How many times per week do you eat fast food?	
How many times per week do you eat at a sit-down restaurant?	
Do you consume caffeine?	
Use of Tobacco products?	
Alcohol Use? *If yes, how many drinks are consumed per week?*	

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Physical Activity (describe):

Current Quality of Sleep *On a scale of 1-10*	
What time do you go to bed?	
What time do you wake up?	

Current Stress Level:

OPTIONAL: Please provide any weight-related information that you'd like me to know (i.e. current weight, usual weight, recent weight changes, unintentional weight loss)

By my signature below, I certify the information I provided on and in connection with this form is true and correct to the best of my knowledge.

Client's Signature_____ Date_____

Guardian's Signature_____Date_____

(If client is under 18 years old)