HealthySelfie

Christine Bou Sleiman, MS, RDN, CLT

Nutrition Therapist/Certified LEAP Therapist

Toll Free: 844.314.1432
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NUTRITION AND MEDICAL HISTORY FORM

Please complete the following. All information will remain confidential.

GENERAL INFORMATION

NAME		**DATE**
ADDRESS		**DAY PHONE**
		EVE PHONE
DATE OF BIRTH:		**MOBILE PHONE**
MARITAL STATUS:	**OCCUPATION:**	
PHYSICIAN:	**REFERRED BY:**	

MEDICAL HISTORY

Please complete the following. Explain any "YES" answers below.

Heart Disease		Seasonal Allergies		Chronic Cough	
Stroke		Arthritis		Asthma	
High Blood Pressure		Osteoporosis/ Osteoarthritis		Attention Deficit Disorder	
Chest Pain		Ulcers		Reflux/heartburn	
Shortness of Breath		Constipation		Lactose Intolerance	
Irregular Heartbeat		Chronic Diarrhea		Dizziness	
High Cholesterol		Irritable Bowel		Fainting	
Swelling of Feet/Hands		Colitis		Anxiety	
Gallbladder Disease		Crohn's Disease		Depression	
Diabetes		Low Back Pain		Disordered Eating	
Kidney Disease		Gout		Suicide Attempt	
Thyroid Disease		Frequent Headaches		Self-Mutilation	
Liver Disease		Eczema		Alcohol Abuse	
Lung Disease		Skin Disorders		Drug Use	
Cancer		Celiac Disease		Tobacco Use	
Anemia		Fibromyalgia		OTHER Illnesses	
Sinusitis/Rhinitis		Chronic Fatigue Syndrome			

Please Explain any YES answers:

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LIST ALL MEDICATIONS, VITAMINS & HERBAL PREPARATIONS

Please include prescription and over-the-counter drugs and vitamins.

1.
2.
3.
4.
5.
6.
7.

WHAT ARE YOUR MAIN HEALTH CONCERNS/TREATMENT GOALS?

1.
2.
3.
4.
5.

WEIGHT HISTORY

HEIGHT	CURRENT WEIGHT	DESIRED WEIGHT
LOWEST WEIGHT IN PAST YEAR	HIGHEST WEIGHT IN PAST YEAR	
DO YOU WANT TO LOSE/GAIN/MAINTAIN WEIGHT?		
IF APPLICABLE, WHEN (AND HOW) DID YOUR EXCESS WEIGHT GAIN OR WEIGHT LOSS BEGIN?		

DIETING HISTORY **Please list ANY previous weight loss attempts.**

TYPE	RESULTS	TIME ON DIET

EXERCISE HISTORY

DO YOU EXERCISE?	IF NO, WHY?	
TYPES	**HOW OFTEN?**	**FOR HOW LONG?**
DESCRIBE OTHER PHYSICAL ACTIVITIES		
WHAT KINDS OF CIRCUMSTANCES INTERFERE WITH PHYSICAL ACTIVITY?		

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CHOOSE THE BEST DESCRIPTION OF YOUR ENERGY LEVEL

	Usually energetic/occasionally tired
	Average energy– sometimes more energetic/sometimes more tired
	Frequently tired/occasionally energetic
	Always tired/no energy

FOOD CHOICE INVENTORY

FOOD DISLIKES	FOOD ALLERGIES/INTOLERANCES

MEAL PLANNING

WHO PLANS MEALS?	WHO COOKS?
WHO SHOPS?	IS A LIST USED?
HOW MANY PEOPLE IN YOUR HOUSEHOLD?	

DINING OUT

HOW OFTEN DO YOU EAT OUT EACH WEEK? /WHAT MEALS?
HOW MANY TIMES WEEK DO YOU EAT AT A FAST FOOD RESTAURANT?

BEVERAGES

DO YOU DRINK ALCOHOL?	TYPES	WEEKLY AMOUNT
DO YOU DRINK COFFEE/TEA?	REGULAR or DECAF	DAILY AMOUNT
OTHER BEVERAGES?		DAILY AMOUNT

FOOD HABITS

DO YOU SKIP MEALS?	IF YES, WHAT MEALS AND WHY?
DO YOU CRAVE CERTAIN FOODS?	WHAT?/WHEN?
DO YOU EAT BEFORE BEDTIME?	WHAT?
WHAT DO YOU FEEL ARE YOUR WORST EATING HABITS?	
WHAT ARE YOUR FOOD DISLIKES?	

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ALLERGY HISTORY

DOES ANYONE IN YOUR FAMILY HAVE ALLERGIES?
IF YES, WHO?
DO YOU HAVE ANY KNOWN ALLERGIES?
LIST ALL FOODS, ADDITIVES, AND MEDICATIONS THAT YOU KNOW OR SUSPECT YOU ARE ALLERGIC TO: