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| Initial Patient Consult Form | | | | | | | | |
| Last Name | First Name | | | | | Referring Physician | | |
| Phone | Alt. Phone | | | Gender  Male Female | | | | Date of Birth/Age |
| Street Address | | City | State | | Zip | | Email Address | |

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| Health History | | | | | | | | | |
| Health and Wellness Goals: | | | | | | | | | |
| Chief Complaints (Duration in parentheses): | | | | | | | | | |
| Treatment History (What have you tried?): | | | | | | | | | |
| Height: | | | Current Body Weight: | | | | Goal Body Weight: | | |
| Ever been tested for Celiac Disease/When/Results? | | | | | | | | | |
| **Circle (or Write in) All Medical Conditions You Have Been Previously Diagnosed With:** | | | | | | | | | |
| Arthritis, Rheumatoid | | Crohn’s Disease | | | | Hypoglycemia | | | Fructose Intolerance |
| Arthritis, Osteo | | Depression | | | | Interstitial Cystitis | | | Eating Disorder |
| Asthma | | Diabetes | | | | Irritable Bowel Syndrome | | | Vitamin D Deficiency |
| Attention Deficit Disorder | | Eczema | | | | Lactose Intolerance | | | Thyroid Disease (Hypo-, hyper-, or other) |
| Celiac Disease | | Gastro esophageal Reflux | | | | Migraine | | | Other: |
| Chronic Fatigue Syndrome | | Hives | | | | Rhinitis | | | Other: |
| Colitis | | Hypertension | | | | Ulcerative Colitis | | | Other: |
| List ALL Medications are you currently taking: (OTC, supplements & Rx – specify which meds for which condition): | | | | | | | | | |
| Are there any known foods that “don’t agree” with you? List all foods, additives or medications you KNOW cause you problems: | | | | | | | | | |
| Does anyone in your family, including you have allergies of any kind (in other words, cat, dust, pollen, food, meds, etc.)? | | | | | | | | | |
| Eating Habits/Lifestyle Considerations | | | | | | | | | |
|  | My life is very stressful. | | |  | I hardly ever go out in the sun. | |  | I crave carbohydrates (bread, pasta) and sugar. | |
|  | I don’t exercise more than 30 minutes three times a week. | | |  | I am bothered by scents (perfumes, soaps, gasoline, tobacco, chlorinated water). | |  | Have you had jock itch, yeast infections, toenail fungus, dry scaly patches on your skin or a diagnosed fungal infection? | |
|  | I drink more than three alcoholic beverages a week. | | |  | I drink coffee or other caffeinated beverages every day. | |  | There is evidence of mold in my living and/or work environment. | |
|  | I smoke cigarettes or cigars. | | |  | I have mercury fillings in my teeth. | |  | I mostly drink chlorinated, fluoridated, and/or bottled water. | |
|  | I am exposed to pesticides, toxic chemicals, and/or heavy metals. | | |  | I sleep less than eight hours a night. | |  | I am sensitive to cold and/or am always cold. | |
|  | I am exposed to toxic bosses, coworkers or family members. | | |  | I experience water retention/weight fluctuations (shoes, jewelry, watches, clothes fit tighter or looser) on a day-to-day or weekly basis. | | | | |

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| Have you been diagnosed with an eating disorder? | How often do you cook from scratch? | | | How often do you eat out? |
| What areas of your life do your health problems interfere with? | | | | |
| What foods (if any) do you crave? | | | Is there any food you could not give up for 2 weeks? | |
| Do you ever eat for comfort? What situation(s) cause you to eat for comfort? | | | | |
| On a scale from 1-10, how badly are these problems affecting your life? | | On a scale from 1-10, how committed are you to getting better? | | |

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| Additional Notes |
| Anything else you’d like to share: |

**3 Day Food Journal**

**Instructions:** Record all foods, liquids, water and meds consumed for 3 days. The information you record in your Food/Symptom Diary is essential to help you and your dietitian identify potential hidden food reactions. These instructions will help you get the most out of your food/symptom diary. Be sure your dietitian receives copies of your food records prior to appointments.

**Instructions:** Record just one food per line. Record all foods, liquids, water and meds consumed. Note also any specials activities, weather, illness, and any other observations. Feeling any symptoms at any time? What are they and how severe?

**BASIC RULES FOR KEEPING A FOOD/SYMPTOM DIARY**

1. Write down everything that you eat or drink, including all foods, beverages, supplements, vitamins, etc. Include all your meals and between-meal snacks from the time you get up until you go to bed.

2. Be honest! The form is useful only if completely and accurately filled out every day.

3. Keep your form with you all day. Write down the information as soon as you finish eating, since meals are difficult to recall in detail after time has passed.

4. Describe the type of food you have eaten, giving as many details as possible. For example, if you drank milk, indicate whether you had whole, skim, or 2% milk.

5. Describe how the food was prepared: raw, baked, boiled, steamed, etc. Also indicate if you followed any other special preparation or cooking techniques.

6. When recording your food diary, imagine that someone wants to duplicate your meals as closely as possible and needs to know as many details as possible about what you ate.

7. Feel free to make copies of this form, saving one as an ‘original’ and print out, filling in by hand. Or, type in foods and keep on your computer to be emailed as attachments.

**NOTE ABOUT THE FORM/COLUMNS:**

Date/Time: Be sure to note the day of week and the date. Write the time of day you ate the food OR had any symptoms.

Meds/Supplements: Note the time and any medications, supplements or herbs you are taking.

Food Eaten/Amount/Description: Write down the type of food you ate. Be as specific as you can.

Indicate the amount of the particular food item you ate. Estimate the size (in inches), the volume (1/2 cup or 1 tsp), the weight (2 ounces) and/or the number of items (12 French fries) of that type of food. Add any details, such as fresh, frozen, or canned, decaf or regular, how the item was prepared, or a brand name, whole grain, organic, or enriched, Etc. Use as many lines/as much space as needed, rather than crowding information.

SYMPTOMS: In this column record ALL physical symptoms. For some items, you may want to rate the symptom on a scale of 1-10 (1 meaning barely perceptible symptom. 10 meaning the most severe.) To make record keeping easier, for some common symptoms, you may want to develop some abbreviations. “D” for diarrhea, “C” for constipation. “M” for migraine, etc. (For example, D-1 might be very minimal diarrhea, M-10 would be a very severe migraine.) Just note what the abbreviations are someplace on each page, or when first listed. You can also rate how were you feeling while you were eating (for example, sad, happy, depressed). And, note if you feel great/no symptoms, etc.

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| Date/Time | Meds/supplements | Food Eaten, Amounts and Description:  brand preparation, etc | Symptoms |
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