



If you are a new patient, please complete all fields. If you are an existing patient, please complete your name and DOB only and skip to Section 2.

SECTION 1

Name: _____ DOB _____ Today's Date: _____
Address: _____ City / State / Zip: _____
Best contact phone number : _____ Email: _____
Who referred you to our office?: _____

SECTION 2 – Please answer the following questions on a scale of 1-10. 1 = very poor 10 = very good

How do you rate your current state of overall health? _____ If not a 10, what do you need to do to get you to a 10? _____

How do you rate your current diet? _____ If not a 10, what needs to change to get you to a 10? _____

How do you rate your current level of motivation to get healthier (more active/eating better/less body weight)? _____
If not a 10 now, what do you need to do to get you to a 10? _____

Why do you want to get healthier (be as specific as possible)? _____

SECTION 3 – Please fill in the blanks and check boxes as needed.

Please list all current prescription medications: _____

Please list all over the counter medications (used 1 x per week or more): _____

Please list all supplements/vitamins you take regularly: _____

History of high blood pressure? Self Mother Father

History of diabetes? Self Mother Father If yes: Type I Type II

History of cancer? Self Mother Father Type: _____

Any problems with thyroid or other autoimmune diagnoses? Self Mother Father Type: _____

Any Surgeries? No Yes (please list procedure and year performed) _____

SECTION 4

Please list your present weight (if known): _____ Height: _____ Desired Weight: _____

What has motivated you now to seek a weight loss and nutrition program?

Have you tried other weight loss programs? Yes No If yes, which one(s)?

What did you like about them?

What did you dislike, or what didn't work?

How often do you eat at fast food restaurants? daily 1-3 times per week 1-2 times per month or less

How often do you eat out? (non-fast food) daily 1-3 times per week 1-2 times per month or less

What restaurants do you frequent?

Any Food allergies? Yes No If yes, list here: _____

Please list your total Inflammation Score from your Inflammation Assessment: _____

Age of oldest known grandparent to have ever lived: _____ Your current age: _____ **M-PYR:** (leave blank) _____

HIPAA Privacy Practices

I acknowledge that I have received and /or have been given the opportunity to review Functional Nutrition/Gard Wellness Center's Notice of HIPAA Privacy Practices for protected health information. These are available on our website, at the Reception Desk and on the table in the Reception room.

Print Patient's Name _____ Patient's Signature _____ Date: _____

Consent to Treat a Minor: (Minor's Printed Name) _____

Parent / Guardian's Signature Authorizing Care _____ Date _____

SIGNATURE OF PHYSICIAN: _____

Date: _____