Family Chiropractic & Wellness

Nutritional Consultation Form

Name		Date of Birth	Age
Address		City	
State	Zip	E-mail	
Employer		Occupation	
Employer's Address:			
Height:	Weight 6 months ago:	How would you rate your current health? [ ]good [ ]fair [ ]poor	
Current Weight:	Desired weight:		
What assistance are you seeking?			

Past Medical History:

List any surgeries you have had in the past (including year): _____

_____

_____

List any medications, vitamins and/or supplements you take, along with dosage:

_____

_____

_____

_____

_____

_____

Do you currently have or have you had any conditions such as Diabetes, cancer, Heart Disease, high cholesterol, eating disorders, ect? Please list. _____

_____

_____

Family History:

Please check any/all of the following that any family members have had:

____ Diabetes
____ Heart Disease (heart attack, bypass, stent)
____ Cancer (List type: _____)
____ High Cholesterol
____ Thyroid disorder
____ Gastro Intestinal
____ Mental Health Issues
____ Osteoporosis
____ Other --Please list:_____
_____

Diet & Exercise History:

List any specific goals you might have: _____
_____
_____
_____

What conditions have you had or that you currently have which affect food selection?
_____
_____

Have you ever been on any special diets? (Along with when and how long) _____
_____
_____
_____

How many times a day do you eat? _____

List any food allergies you might have: _____
_____

What are your favorite foods that you eat regularly? _____
_____

What are foods that you dislike? _____
_____

How often do you exercise? _____

How often do you drink alcoholic beverages? _____ How many beverages? _____

Do you smoke or use tobacco products? _____ If so, how often?_____