Imagine Wellness
PATTY ANN FORD

INITIAL ASSESSMENT

Please answer all questions as honestly as you can. You may leave blank any questions you do not feel comfortable answering. Write "N/A" for any question that does not apply to you.

GENERAL INFORMATION

Patient Full Name:

Date of Birth:

Age:

Primary Physician:

Home Address:

Street:

City: State:

Postal/Zip:

Telephone:

Is this phone your cell or work number?

- ☐ Cell
- ☐ Work

Email:

Occupation (if retired, note previous occupation):

Employer:

Marital Status:

Who live in your household?

Circle last year of school attended, and degree if appropriate:

School year: 1 2 3 4 5 6 7 8 9 10 11 12

College: 1 2 3 4

Masters level doctorate

Other schooling attended?

Insurance Company: **Group # or Policy:**

Does your insurance reimburse for Medical Nutrition Therapy?

Recommending MD/Surgeon/Therapist/Healthy Professional:

MEDICAL HISTORY

Please indicate past and/or current conditions:

- ☐ Anemia
- ☐ Diabetes (type I or type II)
- ☐ Hearing loss
- ☐ Asthma
- ☐ Bronchitis
- ☐ Lung Disease
- ☐ TMJ
- ☐ Joint Problems/Shoulder/Back/Hip
- ☐ Back/Spinal Injury
- ☐ Head Injury
- ☐ Hernia
- ☐ Tumors
- ☐ Eating Disorders
- ☐ Allergies
- ☐ Arthritis
- ☐ Cancer
- ☐ High blood pressure
- ☐ Hypoglycemia
- ☐ Osteoporosis
- ☐ Spinal Cord Injuries
- ☐ Broken Bones
- ☐ Gastrointestinal/Stomach Problems
- ☐ Heart attack
- ☐ High Cholesterol
- ☐ Thyroid Problems
- ☐ Menstural Difficulties

List and describe any other medical condition relevant:

DIETARY HABITS AND WEIGHT HISTORY

Current Height:

Current Weight:

Hightest Adult Weight:

Date:

Lowest Adult Weight:

Date:

Goal/Desired Weight:

How often do you weight yourself:

Food or Medication Allergies:

Do you take vitamins, minerals, or nutritional supplements? If yes, which ones and how much?

How would you describe your current weight?

How satisfied are you with the way you look currently?

How does your weight affect your daily activities (getting dressed, etc.)?

Why do you want to change your weight at this times (weight gain or loss)?

Do you ever use laxatives, diuretics or diet pills to control your weight?

Are you concerned about weight gain?

When is the first time you can recall being concerned with your weight?

How much time do you spend thinking about food, your weight, or how your body looks?

Do you ever go on a food eating binge, where you eat more than a typical meal portion and/or feel you won't be able to stop eating?

Do you ever vomit after you eat? **If so, how often?**

Do you count calories or fat grams?

Do you restrict to a set number of calories per day? If so how many?

Do you understand how to read food labels?

Have you followed other diets, medical nutrition therapy plans or methods involving nutirtion related behavoir change?

Do you eat with friends and/or family?

Do you ever feel guilty or ashamed when you eat?

Can you tell when you are physically satisfied with the amount of food you have eaten?

Can you tell when your stomach is “full”?

Can you tell when your stomach is “stuffed”?

How do you decide what foods to eat?

How do you decide when to eat?

How do you decide how much to eat?

How do you decide when to stop eating?

Can you tell when you are physically hungry?

Do you know if you are eating or drinking for reasons other than hunger or thirst?

List your favorite foods:

Are there any foods that you avoid or will not eat at all?

OTHER HISTORY

Do you ever have heartburn or feel bloated?

Do you have any dental problems, or problems swallowing or chewing?

Do you have trouble with brittle nails or hair that is falling out?

Have you ever missed a monthly period? When/how long?

If not, are your periods light or irregular?

List any current or past forms of exercise:

Has anyone ever told you they were concerned about your eating habits?

GOALS

Please write 3 goals for seeking out coaching, counselling and or treatment for your concerns:

1.

2.

3.