Northern Nutrition

**1125 E Polston Ave, Suite A**
**Post Falls, ID 83854**
**Phone: (208) 640-4502**
**Fax: (208) 777-7330**
**Email: admin@northernnutrition.net**
**Web: www.northernnutrition.net**

# New Patient Intake Form

All information received on this form will be treated as strictly confidential. Please fill out the form completely and accurately. This information is essential to helping us develop a nutrition plan that addresses your needs, goals, and interests that is also safe and effective.

| | | |
|---|---|---|
| Patient Name: | | Gender: ☐ M ☐ F |
| Date of Birth: | Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Divorced ☐ Widowed | |
| Social Security Number (required to bill insurance): | | |
| Mailing Address: | | |
| City: | State: | Zip: |
| Home Phone: | Work Phone: | Cell Phone: |
| Email: | | |
| Occupation: | ☐ Retired ☐ Out of Work/In Between Jobs | |
| Primary Care Physician: | | |
| Referring Physician: | | |

How did you hear about *Northern Nutrition*? ☐ Healthcare Professional ☐ Friend/Family Member ☐ Billboard ☐ Insurance Website

Would you be open to having a student or trainee sit in on your visit(s) with us as a teaching tool for them? ☐ Yes ☐ No

## Insurance Information. **If we are billing insurance, please bring your card(s) to your appointment.**

Not all insurance companies provide coverage for Medication Nutrition Therapy or Nutrition Counseling. Please verify coverage with your provider. Note that patients are responsible for all non-covered charges, including co-pays, co-insurance, deductible, and/or non-covered services.

**Primary Insurance Carrier:**

Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Subscriber ID #: Group #:

**Secondary Insurance Carrier:**

Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Subscriber ID #: Group #:

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**Anthropometrics**

| Height: | Current Weight: | Desired Weight: |
|---|---|---|

Have you gained or lost weight in the last 6 months to a year? ☐ Yes ☐ No

Please explain:

Are you pregnant? ☐ Yes ☐ No Due Date:

What is the primary reason for your visit?

**Readiness**. On a scale of 1 (not willing) to 5 (very willing), please indicate your readiness/willingness to do the following:

| *To improve your health, how ready/willing are you to…* | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|
| Make significant changes to the types of foods you eat | ☐ | ☐ | ☐ | ☐ | ☐ |
| Engage in regular exercise/physical activity | ☐ | ☐ | ☐ | ☐ | ☐ |
| Keep a food diary of everything you eat each day | ☐ | ☐ | ☐ | ☐ | ☐ |
| Change the timing of the meals you eat during the day | ☐ | ☐ | ☐ | ☐ | ☐ |
| Include regular healthy and structured snacks in your day | ☐ | ☐ | ☐ | ☐ | ☐ |

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## Medications and Supplements

Please provide the names of any medications and/or supplements that you are currently taking. Include both prescription and over-the-counter medications and supplements. Please also list any meal-replacement products (i.e. *SlimFast*) and calorie/protein drinks (i.e. *Ensure*):

| Medication/Supplement | Dose | Reason for taking this | Start Date |
|---|---|---|---|
| **Example: Lipitor** | **20 mg** | **High cholesterol** | **May 2011** |
| **Example: One-a-Day Vitamin – Women's 50+** | **1 tablet** | **General health** | **Jan 2012** |
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## Medical History

Please indicate whether you or your relatives* have been diagnosed with any of the following diseases or conditions.
*Relatives include: parents, grandparents, and siblings

| DISEASE/CONDITION | Self | Relative | DISEASE/CONDITION | Self | Relative |
|---|---|---|---|---|---|
| ADHD | ☐ | ☐ | Hepatitis | ☐ | ☐ |
| Allergies (non-food) | ☐ | ☐ | High Triglycerides | ☐ | ☐ |
| Alzheimer's/Dementia | ☐ | ☐ | HIV/AIDS | ☐ | ☐ |
| Amputation | ☐ | ☐ | Hypertension (High Blood Pressure) | ☐ | ☐ |
| Anemia | ☐ | ☐ | Hyperthyroidism | ☐ | ☐ |
| Asthma | ☐ | ☐ | Hypoglycemia (low blood sugar) | ☐ | ☐ |
| Autoimmune condition | ☐ | ☐ | Hypothyroidism | ☐ | ☐ |
| Anxiety | ☐ | ☐ | Hysterectomy | ☐ | ☐ |
| Autism Spectrum Disorders | ☐ | ☐ | Irritable Bowel Syndrome (IBS) | ☐ | ☐ |
| Bariatric Surgery | ☐ | ☐ | Kidney Disease/Failure | ☐ | ☐ |
| Bowel Resection | ☐ | ☐ | Kidney Stones | ☐ | ☐ |
| Bronchitis | ☐ | ☐ | Lung Disease | ☐ | ☐ |
| Cancer | ☐ | ☐ | Liver Disease | ☐ | ☐ |
| Celiac Disease | ☐ | ☐ | Metabolic Syndrome | ☐ | ☐ |
| Chronic Fatigue Syndrome | ☐ | ☐ | Oral Pain | ☐ | ☐ |
| Cirrhosis | ☐ | ☐ | Osteoarthritis | ☐ | ☐ |
| Constipation | ☐ | ☐ | Osteoporosis | ☐ | ☐ |
| COPD | ☐ | ☐ | Pancreatitis | ☐ | ☐ |
| Crohn's Disease | ☐ | ☐ | Parkinson's Disease | ☐ | ☐ |
| Depression | ☐ | ☐ | Peptic Ulcers | ☐ | ☐ |
| Diabetes, Type 1 | ☐ | ☐ | Phenylketonuria/PKU | ☐ | ☐ |
| Diabetes, Type 2 | ☐ | ☐ | Polycystic Ovarian Syndrome (PCOS) | ☐ | ☐ |
| Diabetes, Gestational | ☐ | ☐ | Prostate Problems | ☐ | ☐ |
| Prediabetes | ☐ | ☐ | Psychiatric conditions | ☐ | ☐ |
| Diarrhea | ☐ | ☐ | Rheumatoid Arthritis | ☐ | ☐ |
| Diverticulosis/Diverticulitis | ☐ | ☐ | Sickle Cell Disease | ☐ | ☐ |
| Eating Disorder | ☐ | ☐ | Sinusitis | ☐ | ☐ |
| Emphysema | ☐ | ☐ | Sleep Apnea | ☐ | ☐ |
| Epilepsy or seizures | ☐ | ☐ | Stroke | ☐ | ☐ |
| Fibromyalgia | ☐ | ☐ | Substance Abuse | ☐ | ☐ |
| Food Allergies | ☐ | ☐ | Swallowing/Chewing Difficult | ☐ | ☐ |
| Food Sensitivities/Intolerances | ☐ | ☐ | Ulcerative Colitis | ☐ | ☐ |
| Gallbladder Disease/Gallstones | ☐ | ☐ | Urinary Tract Conditions | ☐ | ☐ |
| Gallbladder Removal | ☐ | ☐ | Other Disease/Condition (please specify): | | |
| Gout | ☐ | ☐ | | | |
| Heart Attack/Angina | ☐ | ☐ | | | |
| Heartburn | ☐ | ☐ | | | |
| Heart Disease | ☐ | ☐ | | | |
| Heart Failure | ☐ | ☐ | | | |
| High Cholesterol | ☐ | ☐ | | | |

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## Lifestyle

Do you have children? ☐ Yes ☐ No Ages:

Who do you live with?

Which meals do you eat regularly? ☐ Breakfast ☐ Lunch ☐ Dinner ☐ Snacks

Who prepares the majority of your meals?

Who does the grocery shopping?

Where do you grocery shop, and how often?

How much time do you spend cooking/preparing meals each day? Hours/Minutes

| How often do you eat out/take-out each week? | ☐ Rarely | ☐ 1-2 times | ☐ 3-4 times | ☐ 5-6 times | ☐ 7+ times |
|---|---|---|---|---|---|

What restaurants?

Do you find cooking difficult? ☐ Yes ☐ No Describe:

How often do you exercise? ☐ None ☐ Light (1-2x/wk) ☐ Moderate (2-3x/wk) ☐ Active (>4x/wk)

Please describe exercise activity and duration:

Does anything limit you from being physically active?

On average, how many hours of sleep do you get? Weekdays: Weekends:

Do you smoke? ☐ Never ☐ In the past ☐ Currently How long?

Do you drink alcohol? ☐ Never ☐ In the past ☐ Currently How long?

Type/Amount/Frequency?

Drug use? ☐ Never ☐ In the past ☐ Currently How long?

Type/Amount/Frequency?

Indicate daily stressors and rate the level of stress from 1 (extremely low) to 10 (extremely high):

Work: Family: Social: Financial: Health: Other:

What helps you to unwind?

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**Eating Style**. Based on how you eat on a regular basis, please check all that apply:

| | | | |
|---|---|---|---|
| Inconsistent meal pattern/timing | ☐ | Snack late at night | ☐ |
| Skip meals | ☐ | Eat standing up | ☐ |
| Eat very fast | ☐ | Eat in the car | ☐ |
| Eat until you are uncomfortably full | ☐ | Eat while watching TV | ☐ |
| Binge or eat without being able to stop | ☐ | Eat while reading or on the computer | ☐ |
| Use food as a reward | ☐ | Eat with others | ☐ |
| Have specific cravings | ☐ | Eat when bored | ☐ |
| Eat when stressed | ☐ | Eat when you are hungry | ☐ |
| Eat when you are anxious | ☐ | Eat when you are not hungry | ☐ |

Do you follow any special diet or have diet restrictions or limitationsfor any reason (health, cultural, religious, or other)? Please explain:

Have you ever been advised by your physician to follow a special diet? ☐ Yes ☐ No

What type? Are you currently following that diet? ☐ Yes ☐ No

Do you read food labels? ☐ Yes ☐ No

What do you look at on the label?

Do the nutrition facts influence your decision to eat the food? ☐ Yes ☐ No

Do you avoid certain foods or food groups? ☐ Yes ☐ No

What do you avoid?

Please list any food allergies, sensitivities, or intolerances: