Confidential Medical & Nutrition Information

Office of Susan L. Holmberg, MS, CNS

Name: ______________________ Age: ______________

Address: ______________________ Height: ______________

______________________ Weight: ______________

Contact Info.

(Home):		(Work):	
(Pager):		(Cell):	
(Fax):		(Email):	

Check any that apply:

- ☐ Acne
- ☐ Addiction
- ☐ Anemia
- ☐ Anorexia/Bulemia
- ☐ Arthritis
- ☐ Bloating, gas, or indigestion
- ☐ Blood sugar issues
- ☐ Cancer
- ☐ Constipation
- ☐ Depression/Anxiety
- ☐ Type I Diabetes
- ☐ Type 2 Diabetes
- ☐ Diarrhea
- ☐ Difficulty *losing* weight
- ☐ Difficulty *gaining* weight
- ☐ Erectile Dysfunction
- ☐ Gall bladder problems
- ☐ Gout
- ☐ Hair loss
- ☐ Headaches/Migraines
- ☐ Heart disease
- ☐ Heartburn
- ☐ Hemorrhoids
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ High Triglycerides
- ☐ Insomnia
- ☐ Intestinal problems
- ☐ Kidney stones
- ☐ Liver problems
- ☐ Menopause
- ☐ Parasites
- ☐ PCOS
- ☐ PMS
- ☐ Skin conditions
- ☐ Stroke
- ☐ Thyroid condition
- ☐ Yeast infections

Who is your primary care physician?

Name: ______________________ Phone: ______________

Address: ______________________

Specialists:

Name: ______________________ Phone: ______________

Address: ______________________

Name: ______________________ Phone: ______________

Address: ______________________

Name: ______________________ Phone: ______________

Address: ______________________

When was your last physical? ______________________________

List medical conditions
(include allergies/food sensitivities):

Current medications: ______________________________

Current supplements: ______________________________

Relevant Family Medical History:
____

Trauma, accidents or surgeries: ______________________________

Nutrition Information	Never	Rarely	Sometimes	Often
Do you smoke?	☐	☐	☐	☐
Do you drink alcohol?	☐	☐	☐	☐
Do you drink coffee or caffeinated drinks?	☐	☐	☐	☐
Do you exercise?	☐	☐	☐	☐
Sleep Problems?	☐	☐	☐	☐
Do you cook?	☐	☐	☐	☐
Do you experience low energy during your day?	☐	☐	☐	☐
Do you get lightheaded, irritable, or weak if you haven't eaten?	☐	☐	☐	☐

What are the reasons you believe you are overweight?
Please list as many reasons as you can including:
emotional, environmental, medical, genetic, hormonal and lifestyle.
____

Who are the people you see regularly that help you stay overweight?
____

Which of your family members are overweight now or in the past?
____

What other methods have you used to lose/gain weight?
____

Name a specific time(s) or a place(s) when overeating is a problem?
____

How long have you been overweight? ______________

Highest Weight/Age	Lowest Weight/Age	Target Weight

How many of these meals are eaten outside of your home, per week?

Breakfasts	Lunches	Dinners	Snacks

From the list below, describe your eating style (select all that apply):

☐ Grazer ☐ Night Eater ☐ Picker ☐ Snacker ☐ Volume Eater ☐ Starver ☐ No Real Meals ☐ Junk Food Junkie

What foods do you think contribute to your weight gain?
____