NEW CLIENT EVALUATION

DESIGNED CLINICAL NUTRITION

Today's Date: ______________________ Referred by: ____________________________________

Name: ________________________________ M ❑ F ❑ Birthdate ____/_____/____ Age ______

Mailing Address: ____

City: __________________ State: _____________ Zip: _________ Occupation: ______________

Marital Status: S ❑ M ❑ D ❑ W ❑ No. of children: ________________

Daytime phone: _____________________________ Evening phone: _______________________

Email: ____

1. Complaints Please tell us the main reason why you are here

2. Secondary Complaints Please let us know any other health concerns that you have

3. Previous Treatment for these Complaints

4. Medications Please let us know all prescription medications you are taking

5. Major Illnesses Please list any major illnesses and approximate dates

6. Surgeries Please list any surgeries and approximate dates

7. Injuries Please list any accidents or injuries, and approximate dates

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8. WOMEN ONLY

Are you pregnant: ____________________ Are you nursing? ______________________

Date of onset of last menstrual period: ____

Any gynecologic surgeries (hysterectomy, endometriosis, ovarian cysts)? ____________________

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Menstrual Cycle Do you have regular monthly periods? ________________________________

Circle any of the following symptoms you experience associated with your period:

Cramping bloating moody cravings heavy bleeding back pain Headaches clots

9. Sleep (please circle) Trouble falling asleep Can't stay asleep Bad dreams
   Any other sleep problems? ____

10. Pets Any pets? _______ If so, what kind and how many? ________________________

11. Exercise What kind of exercise do you do? ____________________________________
    How often? __________________________ Duration ____________________________

12. Food Allergies Please list ____

13. Dental History Please recall as best you can the types of dental work you have had and the approximate dates on which it occurred.

- ☐ Silver fillings
- ☐ Composite or porcelain fillings
- ☐ Gold fillings or crowns
- ☐ Root canals
- ☐ Veneers
- ☐ Bridge
- ☐ Dentures
- ☐ Extracted teeth

Other: