CLIENT DATA

Date: _____

CONFIDENTIAL

Last Name	First Name	MI	Birthday / /	Male □ Female □
Address	City	State	Zip Code	
Home Phone ( )	Work Phone ( )	Cell Phone ( )	Fax ( )	
E-mail Address	Occupation	Spouse Name		

Family Physician	Phone ( )		
Address	City	State	Zip Code

How were you referred to Healthy Connections?

- ❑ Newspaper
- ❑ Mailing
- ❑ Restart
- ❑ Your Doctor
- ❑ A Friend _____
- ❑ Internet
- ❑ Yellow Pages
- ❑ Weight is unacceptable
- ❑ Outside encouragement
- ❑ Health Issues
- ❑ Other (specify) _____

What do you hope to accomplish with a nutrition program?_____

_____

How can we help you reach that goal? _____

_____

FOR OFFICE USE ONLY

IInitial Weight	Height	Goal Weight	Frame Size □ Small □ Med. □ Large
Wrist	Neck	Upper Chest	Chest
Upper Arms	Ribs	Waist	Abdomen
Hips	Thighs Right Left	Knees Right Left	Calves Right Left

Personal Health Information

YES	NO	EXPLAIN:
		2. Are you a diabetic? Insulin?
		3. Is anyone in your family diabetic? If so, whom?
		4. Have you been diagnosed hypoglycemic?
		5. Have you been diagnosed anemic?
		6. Do you have heart problems? If so, what?
		7. Has anyone in your family been diagnosed with heart problems?
		8. Have you ever been diagnosed with cancer? Type:
		9. Has anyone in your family been diagnosed with cancer?
		10. Have you ever had kidney stones? When?
		11. Have you ever had gallbladder disease/stones?
		12. Have you ever had any gastrointestinal disorders? What & When?
		13. Have you ever been diagnosed with gout? When?
		14. Do you have high blood pressure/hypertension?
		15. Do you have headaches? What type and how often?
		16. Do you have arthritis?
		17. Do you have any allergies or intolerances? What?
		18. Do you have asthma?
		19. Do you have premenstrual syndrome (PMS)? How treated?
		20. Are you troubled with constipation? How often?
		21. Have you had any surgeries? What type and when?
		22. Are you pregnant or lactating at this time? Due Date:
		23. Are you taking medications? What kinds & why? Include hormones, diuretic, birth control & OTC meds.
		24. So you have any other physician diagnosed health problems? What?:
		25. Do you consider yourself to be in good health?
		26. Are you a smoker? If yes, how many packs a day?
		27. Are you overweight? If so, how much & how long?
		28. What is your present weight? One year ago:
		29. Have you ever been anorexic or bulimic?
		30. Do you take vitamins or mineral supplements regularly? Type:
		31. Do you have any health concerns that prohibit you from a regular exercise program?
		32. Will there be family members or friends who will be supportive of your nutritional program? Who?

Healthy Connections Client Profile

Personal Information – Eating Habits (Confidential)

1. What times do you usually eat?
   - 6-8 a.m.
   - 8-10 a.m.
   - 10-noon
   - Noon-3 p.m.
   - 3-6 p.m.
   - 6-8 p.m.
   - 9-Midnight
   - Midnight-5 a.m

2. When are you hungry?
   - Morning
   - Mid-Morning
   - Noon
   - Mid-afternoon
   - Evening
   - Late Evening

3. How often do you eat out?
   - 1-2 times/week
   - 5-6 times/week
   - 3-4 times/week
   - Every day

4. What beverages do you drink? How many?
   - Coffee _____
   - Tea _____
   - Soft Drinks _____
   - Alcohol _____
   - Water _____
   - Other _____

5. What kind of foods do you enjoy eating?
   - Sweets/desserts
   - Ice Cream/Frozen Yogurt
   - Cheese/spreads/dips
   - Fresh vegetables
   - Nuts/candy
   - Fast Foods
   - Fresh Fruit
   - Bread/crackers
   - Pretzels/chips
   - Peanut Butter
   - Pasta/Pizza
   - Meats/Fish

6. My least favorite foods are:

_____

_____

_____

(a) Any food allergies? _____

_____

_____

7. I eat when I am down or depressed. yes no
8. I crave sweets when I am "down." yes no
9. Eating seems to make me feel better. yes no
10. I drink alcohol or eat to pick me up. yes no
11. My life feels out of control most of the time. yes no
12. I have prescribed medication for depression. yes no
13. I eat to handle the pressures in my life. yes no
14. I eat when I am anxious or nervous. yes no
15. I eat more when I am stressed. yes no
16. I eat more when I am sad. yes no
17. I weigh myself everyday. yes no
18. I get excited when my weight is down. yes no
19. I get depressed when my weight is up. yes no
20. At times my eating is totally out of control. yes no
21. Do you start snacking right after a meal? yes no
22. Do you add salt to your food while cooking? yes no
23. I primarily (bake fry broil) meats?
24. When you eat at home, who usually does the cooking?
25. How many do you cook for?

Personal Information – Physical Activity

1. More than 25% of my time at home or at work is: (check all that apply) Sitting Standing Lifting Walking Driving

2. How often a week do you exercise? Duration?: _____
   - Every day
   - 4-5 times/week
   - 2-3 times/week
   - Never

3. What type(s) of exercise do you do?
   - Walking/Jogging
   - Weight Training
   - Aerobics/Step Aerobics
   - Other:

4. I like exercise that gets my heart pumping.
   Yes No

5. I like to exercise. Yes No
6. I can briskly walk 4 miles without fatigue. Yes No
7. I belong to a club where I can workout. Yes No
8. I like to be an active participant in social activities. Yes No
9. I watch TV or read more than 30 hrs/wk. Yes No

Autoimmune Symptoms:

Check the box beside all symptoms you are experiencing:

- ☐ abdominal cramping
- ☐ abdominal pain
- ☐ abdominal swelling
- ☐ abdominal tenderness
- ☐ abnormal growths
- ☐ abnormal tissue formation
- ☐ abscess
- ☐ acid reflux
- ☐ agitation
- ☐ allergies
- ☐ anemia
- ☐ bacterial infection
- ☐ bloating
- ☐ blood in stools
- ☐ burning pain
- ☐ drowsiness
- ☐ fainting
- ☐ fatigue
- ☐ fistula
- ☐ flatulence
- ☐ fungal infections
- ☐ excess gas
- ☐ gland or lymph problems
- ☐ hair loss
- ☐ headache
- ☐ hemorrhoids
- ☐ high blood pressure
- ☐ high blood sugar levels
- ☐ high cholesterol
- ☐ hormonal imbalances
- ☐ immune problems
- ☐ intestinal bleeding
- ☐ intestinal obstruction
- ☐ Irritability
- ☐ joint inflammation
- ☐ joint pain
- ☐ loss of muscle tone
- ☐ low blood sugar levels
- ☐ memory loss
- ☐ menstrual problems
- ☐ migraine
- ☐ nasal inflammation
- ☐ nausea
- ☐ parasitic infections
- ☐ polyps
- ☐ rectal bleeding
- ☐ skin disorders
- ☐ tissue degeneration

- [ ] confusion
- [ ] constipation
- [ ] depression
- [ ] diarrhea
- [ ] digestive problems
- [ ] indigestion
- [ ] Infections
- [ ] inflammation (general)
- [ ] insomnia
- [ ] ulcers
- [ ] vision loss
- [ ] yeast infections

Specific explanations here: