Piedmont

WELLNESS CENTER

REQUEST FOR NUTRITIONAL COUNSELING

STATISTICS

Name		Age	Date of Birth
Height	Current Weight (optional)	Children + Age	
Occupation			
Exercise/Recreation			
Primary reason for seeking nutritional support			

PAST MEDICAL HISTORY

I have had my labs drawn within the last 6 months

☐ Yes ☐ No (please bring copy of labs to consult if drawn within the last 6 months)

Please check any that apply to your past medical history

☐ Cancer	☐ High Cholesterol	☐ Anemia	☐ Diabetes
☐ Asthma	☐ Hepatitis	☐ Thyroid Disease	☐ Venereal Disease
☐ Depression/Anxiety	☐ Heart Disease	☐ Kidney Disease	☐ Chronic Yeast Infection
☐ High Blood Pressure	☐ Allergies	☐ IBS	☐ Chron's or UC Eating disorder
☐ None of above			

Treatment

CURRENT HEALTH CONCERNS

Do you have any health concerns beyond the nutritional goals listed above?

What health practitioners are you currently seeing?

List Name, Specialty, and Phone Number below:

List medicines/pharmaceuticals you are currently taking:

List all nutritional supplements, vitamins, minerals and herbs you are currently taking:

Continued on the next page

A DEEPER LOOK

The following questions relate to the aspects of wellness most closely associated with your nutrition goals.

HYDRATION: What do you typically drink throughout the day? And what is your average liquid consumption [estimate]?

METABOLISM: Have you experienced any recent fluctuations in weight?

DIGESTION: Do you have any other digestive issues not yet mentioned [ex: bloat, cramping, constipation, loose stool etc]?

INFLAMMATION: Are you currently injured? Or are you experiencing any chronic inflammation? If so - where?

ENERGY: Does your energy fluctuate much throughout the day? If so- when is it usually at its lowest?

SLEEP: Do you suffer from insomnia? If so- at what point in the night?

STRESS: On a scale from 1-10 how high is your stress right now?

FOOD INTOLERANCES

Do you have any known food allergies [anaphylactic response], sensitivities, or intolerances?

Do you have symptoms IMMEDIATELY after eating like bloating, gas, sneezing or hives? If so, please explain:

Are you aware of any DELAYED symptoms after eating certain foods such as fatigue, muscle aches, sinus congestion, etc...? If so, please explain: