PATIENT INFORMATION SHEET

Today's Date:_____ **Date of Birth**: _____/_____/_____

Name: _____Sex: F___M____

Address: _____

City: _____**State** _____ **Zip** _____

Phone Numbers: (H)_____(W)_____(Cell)_____

Email:_____ **Occupation**: _____

Education:_____ **Ethnic Background:** _____

Height: _____ **Current Weight:** _____ **Age:** _____

Primary Care Physician: _____ **Phone:** _____

Referred by:_____
==========

Primary / Secondary Health Concerns:

	Severe	Moderate	Slight	Please list them in order of importance to you:
1.	☐	☐	☐	_____
2.	☐	☐	☐	_____
3.	☐	☐	☐	_____
4.	☐	☐	☐	_____
5.	☐	☐	☐	_____

Briefly describe why you are seeking nutritional counseling services: _____
_____
_____
_____

Current / recent health care providers:

Name Dates Care Provided

_____
_____
_____

Allergies Y / N

Food	**Symptoms:**
Other:	**Symptoms:**

LILYPOND, LLC - Nutrition Therapy and Reiki Treatments
Karin Dietrich - MNT **Tel. 303-912-1100** **email: info@lilypondhealth.com**

Personal Health History: Please mark the following: 1 – if current, 2 – if past

___ Respiratory Problems_____
___ Asthma_____
___ Allergies / Type:_____
___ Frequent Colds/Flu_____
___ Sinus Congestion _____
___ Chronic Fatigue _____
___ Immune System Disorders_____
___ HIV / AIDS_ _____
___ Frequent Infections_____
___ Gastro-Intestinal Problems _____
___ Colitis / Crohn's _____
___ Parasites _____
___ Candida _____
___ Gas / Bloating _____
___ Chronic Constipation _____
___ Diarrhea_____
___ Diabetes / Type_____
___ Hypo or Hyperglycemia _____
___ Overweight / Underweight_____
___ Eating Disorders_____
___ Heartburn / Reflux_____
___ Heart Disease / CVD_____
___ Heart Attack_____
___ High Blood Pressure_____
___ Stroke_____
___ Water Retention / Edema_____

___ Cancer Type:_____
___ Migraines / Frequent Headaches_____
___ Sleep Apnea_____
___ Muscle cramps / spasms _____
___Osteoporosis_____
___ Osteoarthritis_____
___ Rheumatoid Arthritis_____
___ Inflammation, site: _____
___ Frequent Infections_____
___ Eye Problems_____
___ Thyroid Disorder_____
___ Skin Problems _____
___ Urinary Problems_____
___ Stress_____
___ Shortness of Breath_____
___ Anxiety_____
___Depression_____
___ Mood Swings_____
___ ADD / ADHD_____
___ Alcoholism_____
___ Sleep Problems_____
___ Liver Problems_____
___ Menopausal Problems_____
___ Menstrual Problems_____
___ Fertility Problems_____
___ Autoimmune Disease_____

Other: _____
_____
_____

Hospitalizations / Surgeries:_____
_____
_____

Recent Lab Tests or Diagnostics: _____
_____

Family Health History: **Health Issues** **Age**
Parents: _____
_____
Siblings_____
_____
_____
Grandparents:_____
_____

LILYPOND, LLC - Nutrition Therapy and Reiki Treatments
Karin Dietrich - MNT **Tel. 303-912-1100** **email: info@lilypondhealth.com**

Current Medications / Supplements: Please list all prescriptions and over-the-counter medications as well as supplements, vitamins, minerals, etc.

Medication	Since	Any side effects

Supplement / Herbs	Since	Frequency of intake / Dosage

Have you recently gained _____ or lost _____ weight? Amount _____
If so, over what time frame did you gain / lose this weight? _____

Diets followed in the past, effectiveness, eating disorders: _____
_____
_____

Tobacco use: How much _____ For how long? _____ Past use if not now: _____
Alcohol use: How much _____ How often: _____ Preferred type:_____
Caffeine use: How much? _____ In what form? _____

Physical Activity / Exercise:
Type(s): _____
Intensity: Low / Med / High Duration: _____ minutes / hours
Frequency:_____ times/week Are you consistent? _____
Any discomfort/pain? _____
_____

SLEEP PATTERN / ISSUES:
Average hours sleep/night: _____ Awake feeling rested? Y / N / Sometimes
Sleep apnea __ Restless Sleep ____ Trouble falling asleep ____ Waking up _____
Other (please comment): _____

STRESS LEVEL: Please rate on a scale from 1-10, 1 being the lowest _____
What type / cause of stress? _____
How do you cope with stress / outlets / balancing? _____
_____

Please rate the following on a scale from 1 to 10 (10 being the best) – write in any comments / concerns:
ENERGY LEVEL: Level _____ Comments: _____
_____
Time of highs/lows:_____
Do you know what causes hi/lo?_____

APPETITE: Level _____ Comments: _____
What causes loss / increase?_____

DIGESTION: Level: _____ Comments: _____
_____
Types of discomfort/symptoms observed (if any):_____
_____
Any particular foods that aggravate your digestion?_____
_____

Current / past use of diuretics, diet pills, laxatives, acid blockers: _____
_____

BOWEL ELIMINATION: Regularity (how often) _____
Do you tend towards: Constipation: Y / N Diarrhea: Y / N
Comments or concerns: _____
_____

Typical Day Food Intake:

Time	Food / Liquid	Amount	Setting(i.e. home, rest, w/TV)

How many days per week do you typically eat like this? _____ Weekday or weekend?
Does your pattern differ on weekends (weekdays)? Y N If so, please explain:
_____

What are your favorite foods / flavors?_____
_____
Food aversions / least favorite foods / flavors? _____
_____
How many glasses of water do you drink daily? _____

What do you feel are your biggest nutritional challenges and difficulties? _____
_____
_____

Overall Nutritional / Lifestyle Goals:
_____
_____
_____

How ready and willing are you to make the changes necessary for achieving your goals?

Not at all Ready or willing			Slightly ready and willing			Fairly ready and willing			Very ready and willing	
0	1	2	3	4	5	6	7	8	9	10

_____ _____ _____
Patient Signature Date

LILYPOND, LLC - Nutrition Therapy and Reiki Treatments
Karin Dietrich - MNT Tel. 303-912-1100 email: info@lilypondhealth.com