



LeSash

NUTRITION & HEALTH

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Staten Island, NY 10304
Ph: 347-861-7666 Fax: 866-540-2266

Reminder: Co-Payment Is required at time of your visit

****Please print clearly and complete all information in order for your claim to be processed quickly and efficiently.****

Personal History

Name: _____ Date of Birth: _____

Address: _____

Email: _____ Phone: (H) _____ (C): _____

Sex: Male: () Female: () What is your occupation? _____

Work Hours: _____ Marital Status: () Married () Single () Student

How many children do you have? _____ Age(s): _____

Parent/Guardian/Spouse's name: _____

Physician's name? _____

What is the reason for your visit today? _____

How did you hear about us? _____

Medical and Health History

Height: _____ Weight: _____ Desirable weight: _____ BMI: _____

Your highest Weight as an adult: _____ Your lowest weight as an adult: _____

List any health-related/medical complications: _____

Family health-related/medical history: _____

List any medications you are taking: _____

List all vitamins/minerals/protein supplements you are taking: _____

Medical and Health History, Cont'd

Do you experience: Constipation? ___ Diarrhea? ___ Heartburn? ___ Nausea? ___ Loss of energy? ___

Do you participate in regular physical activity? _____ Type? _____ How Often? _____

Do you smoke cigarettes? _____ How many per day? _____ Any particular time? _____

Do you drink alcohol? _____ When? _____ What? _____

Nutrition History

Are you allergic to any foods? _____ Specify: _____

Are any foods avoided for religious, ethical or other reasons? _____

Have you ever been on a diet/used weight loss products? _____

Specify: _____

Weight change: _____ Length of time on diet? _____

Do you read food labels before purchasing foods? _____

Do you drink coffee/tea? _____ How many cups /day? _____

Do you skip any meals? ___ Indicate which meal: _____

Do you have a problem with snacking? ___ If so, what time of day? _____

Where are most meals eaten? Home: _____ Restaurant: _____ Other: _____

Do you eat more when you are: depressed? ___ stressed? ___ anxious? _____

bored? ___ tired? ___ lonely? _____ happy? ___ socializing? _____

How many servings do you daily consume from these foods:

Milk: ___ Fruits: ___ Vegetables: ___ Starches/grains: ___ Meats: ___ Fats: _____

Signature: Date: _____

Please give 24hour notice for cancellation of appointments or full fees will apply

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