LeSash
NUTRITION & HEALTH

P.O. Box 320648 Brooklyn
NY 11232 - 0648
Cell: 347-205-5166
Fax: 866-540-2266

**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:**

______

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# 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**

Cell.: **347-205-5166** | Fax: **-866-540-2266**
Email: **jlesashnutrition10@gmail.com**

Thank you for completing this questionnaire.