|  |  |
| --- | --- |
| Name:  | Date of Birth:Click or tap to enter a date. |
| Address: |
| Phone # | Email address: | Best way to contact:Choose an item. |
| What nutrition concerns or conditions do you wish to talk about? |
| Do you follow any diet restrictions or are you on a special diet? |
| Was this diet prescribed or recommended by your doctor? [ ]  No [ ]  Yes |
| On the scale below, how well do you follow this diet?  |
| Always [ ]  1 [ ]  2 [ ]  3  | Sometimes [ ] 4 [ ] 5 [ ]  6 [ ]  7 | Rarely [ ] 8 [ ]  9 [ ]  10 |
| Please list any medications (prescribed or over the counter) that you are taking: |
| Are you concerned about your weight?Choose an item. | Current Weight: Current Height:I would like to weigh: |
| What are your goals? |
| *Office Use: Request Date:* | *Consultation Date:* |