LeSash Nutrition & Health, LLC

Counseling * Consulting * Presentations * Workshops

Please complete both sides. All information is kept confidential

PERSONAL HISTORY

Name: _____ **Date Of Birth:** _____

Address: _____

Email: _____ **Phone: (O)** _____ **(F)** _____

What is Your Occupation? _____ **Hours:** _____

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

Physician's Name: _____ **Phone #** _____

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 as an adult:** _____

List any health-related/medical complications _____

_____

Family health-related/medical history _____

_____

List any medications you are taking: _____

_____ _____

_____ _____

List any vitamin/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 food _____ Specify: _____

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

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

Weight change _____ Length of time on diet _____

Do you read food labels before purchasing foods _____

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

Do you skip any meals _____Indicate which meal _____

Do you have a problem with snacking _____ What time of the 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 _____ Vegetable _____ Starches/ Grains _____ Meats _____ Fats _____

Thank you for completing this questionnaire.

Signature ..... **Date** .....

PLEASE GIVE 24HR. NOTICE FOR CANCELLATION OF APPOINTMENT OR FULL FEES WILL APPLY