LeSash
NUTRITION & HEALTH

1864 Clove Road Suites D&E
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): ____________

What is your occupation? ______________________ Hours: ______________

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

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: ________

Thank you for completing this questionnaire.

Signature: .... Date: ________________

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

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