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): _____

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

Tel.: 347-861-7666 Fax: -866-540-2266 jlesashnutrition10@gmail.com www.lesashnutritionhealth.com

Thank you for completing this questionnaire.