

Case Specific NUTRITION COACHING CLIENT INFORMATION

To better serve you, please complete the following information. Please print.

1. Your Demographic Information

Name: _____ Male Female
(Exactly as it appears on your insurance ID card)

Address: _____

Date of Birth: ____/____/____ Age: _____

Phone: Daytime (____) _____ Evening (____) _____

E-mail Address: _____

Insurance Type: _____

Unique Member ID# _____ Group# _____

Primary Cardholder Dependent

2. Primary Care Physician Information

Physician Name: _____

Address: _____

Phone Number: (____) _____

Were you referred by your physician? Yes No

If yes, why were you referred? _____

If you were referred by your physician, we will notify him/her about your visit and your progress in Case Specific Nutrition. Accept Decline

If you were NOT referred by your physician, would you like us to notify him/her about your visit and your progress in Case Specific *Nutrition Coaching*? Yes No

3. Please identify your main area(s) of concern/nutrition goals for *Personal Nutrition Coaching*:

Continued on the next page

4. Personal Health Information

Height _____ Current Weight _____ pounds

Weight History _____

Medical History _____

Tobacco Use _____ Alcohol Use _____

Vitamins/Dietary Supplements _____

Current Medications _____

Exercise Habits _____

Please list your food intake on a typical day:

Breakfast:
Lunch:
Dinner:
Snacks:

-----CLINICAL DATA: FOR STAFF USE ONLY-----

	Initial	Follow-up 1	Follow-up 2
Date			
Weight			
BMI			
Other			