NUTRITION RESOLUTIONS LLC
LAURA L POWERS, B.S., M.ED
(727) 560-1007 **nutritionresolutionsllc - Facebook**
Nutritionresolutions852@gmail.com **nutritionresolutionsll.com**

NEW PATIENT INFORMATION

Success in achieving optimum health and well-being are influenced by a multitude of factors that include family history, culture, lifestyle, nutrition/eating habits, stress levels, , etc. Please complete the following questionnaire to the best of your ability so that we can move forward in achieving your desired goals.

BE HONEST! NO JUDGEMENTS EVER MADE! BEING TRUTHFUL WILL GET YOU TO YOUR GOALS QUICKER!

Name____ **Date**_____________

Address____

City______________________ **State**__________ **Zip**______________

Preferred Phone/Cell Contact #________________ **E-Mail**________________

Occupation______________________

Work Schedule: Days_____ Nights_____ Both!!!!______

Referred By_________________________

Age:	Wt:	Ht:	BP:

What is your major goal or area of interest?
____

FAMILY HISTORY (circle all that apply and specify the relation):

Stroke_________________________
High BP_______________________
Depression_____________________
Heart Disease__________________
Arthritis (RA or OA)_______________
Cancer___ Type?________________

Diabetes: Type 1_____ Type 2____
Weight Problems__________________
Ulcer_____________________________
Psoriasis__________________________
Glaucoma_________________________
Sleep Apnea_______________________

PERSONAL HISTORY (circle all that apply and specify if you can):

Arthritis: RA_____ OA_____	Gallbladder Problems
Stroke	Thyroid Problems
High Cholesterol	Hypothyroidism
How High?_______	Hyperthyroidism
High Blood Pressure	Headaches
How High?_______	Chronic Tension
Heart Disease	Migraines
Angina	Cluster

New Patient Information (cont.)

Diabetes: Type 1_____ Type 2_____ Low Blood Sugar Chronic Fatigue Fibromyalgia Multiple Chemical Sensitivities Frequent Colds/Flu Herpes/ HPV Cold Sores Cancer: Type?______________________ Surgeries: Type(s)? _________________ Digestive Problems? Constipation__ Diarrhea__ Abdominal Cramping/Bloating__ GERD__ Weight Problems Ulcers	Hormonal Food Allergies To What?____________ Seasonal Allergies To What?____________ Medication Allergies To What?____________ Skin Allergies/Conditions Sleep Problems/Sleep Apnea Forgetfulness Hormonal Issues: Hot Flashes__ PMS__ Birth Control Pills/ Hormones__

What Medications and Dosages are you taking? List all prescriptions and over the counter products:

____
____
____
____

What Vitamin/Mineral and/or herbal supplements are you taking?

____
____
____

FOOD PREFERENCES
Do you eat, drink, or use? (circle all that apply):

Antacids	Sweets/Sugary Foods	Protein Drinks
Aspirin	Artificial Sweeteners	Coffee
Tylenol	Desserts/Bakery	Decaf Coffee
Ibuprofen	White Breads/Pasta	Diet Soda
Laxatives	Milk/Dairy Products	Soda
Appetite Suppressants	Fast Foods	Tea
Tobacco	Processed Food Products	Juice
Alcohol	Snack Foods	Fruit Drinks
MM	Red Meat	Latte/Cappuccino

List any food aversions and/or foods you are intolerant to:

____
____

New Patient Information (cont.)

Do you have any diet restrictions due to health, religion, culture, or personal preference?
____
____

Do you *crave* certain foods or drinks? **(circle all that apply):**

Sweets	Chocolate	Bread/Pasta
Fried Foods	Alcoholic drinks	Sodas/Diet Sodas
Meat	Caffeinated Products	Salty/Crunchy Snacks

Other? Please specify____

Describe your normal eating habits: 3 meals a day_____ eating on the run_____
grazing_____ whatever works for that day_____ skipped meals and binge eating_____

Do you plan, prepare, shop, or cook your own meals? yes_____ no_____
sometimes_____ are you kidding?_____
If not, why? Don't have time_____ Don't like to_____ Don't know how_____

What type of restaurants or fast food restaurants do you frequent? (Do they know your name?)____
____

Do you get noticeably irritated, weak, or lightheaded if you haven't eaten in a while?
Yes_____ No_____

DIET HISTORY

Which types of nutrition or diet programs have you tried before?
____
____

What success have you ever experienced with these programs and for how long?
____

What were the primary reasons they failed to work for you?
____

What are your major challenges or triggers? stress_____ travel_____ cost_____
eating out______ Other (please list)____

LIFESTYLE

Do you smoke/vape? Yes_____ No_____

Are you under excessive amounts of stress? at home______ at work______
both!!!!!!!!!!!!!!!______

New Patient Information (cont.)

How would you describe your bowel movements? regular_______ irregular______

Average Hours Sleep per night? ______ Any sleeping problems? yes_____ no_____

If yes, please specify____

PHYSICAL ACTIVITY

Do you regularly participate in an exercise program? yes_____ no_____

depends on schedule______ What are your preferred activities?_____________________

____

Are you physically limited or challenged in any way? Please specify:

____

Have you had any recent surgeries? Please specify:

____

What is your biggest challenge in trying to participate in regular exercise? lazy_____

hate it_____ uncomfortable in gyms_____ no time_____

other____

FAMILY LIFE

Who do you go home to? living solo_____ spouse/partner_____ family_____ pets___

To what extent will you commit to achieving better health?

Little_______ Moderate _______ Major________ **Extreme** - Let's Do It!_______

Is there anything else about either your history or your current condition that you feel is important to mention?

____

____

____

Disclaimer: The scope of our practice here at Nutrition Resolutions, LLC does not include the medical treatment of or diagnosis of specific illnesses or disorders. If you suspect you may have an illness that may require medical attention, please consult with a licensed physician. We do not wish to replace your physician and encourage you to visit a doctor if you have serious health concerns. Rather than dealing with the treatment of diseases, Nutrition Resolutions, LLC focuses on providing wellness and aiding with the prevention of illness through the use of medically based nutrition plans. We teach how to achieve optimal health through smart nutritional decisions and strategies. If you have any questions, please feel free to contact us.

I have read and fully understand the disclaimer above and consent to participate in the Nutrition Resolution, LLC program.

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Signature