



NATION'S BEST

FAMILY HEALTH CARE

Nutrition Background History and Consultation

| | |
|---------------------------------|-------------------------------|
| NAME: | |
| DATE OF BIRTH: | |
| ADDRESS: | |
| CITY: | STATE: |
| PRIMARY PHONE: Cell or Home | SECONDARY PHONE: Cell or Home |
| E-MAIL ADDRESS: | |
| PLACE OF EMPLOYMENT/OCCUPATION: | |

Program Overview

The NBFHC Nutrition program is designed based on Medicare guidelines to improve health and not only lose weight for those who are overweight, but reduce the need for medications for other conditions such as hypertension, high cholesterol, diabetes or joint pains. Your success in the program will depend on your willingness to make changes to improve your nutritional status and increase your activity levels.

The majority of the program is covered by most insurances and your normal copay per visit is also due at each visit. For those not wishing to use their insurance for the program, there are cash pay options available to you as well.

Your visits will be scheduled every 1-4 weeks depending on your progress, generally consisting of 8 visits over 3 months and 12 visits over 6 months with regular weight and vital signs checks at each visit.

Your medications may need to be adjusted during the program to compensate for the changes made in your body as your nutrition improves. You will continue to have scheduled appointments with your medical provider to discuss any medication changes needed during the program. Your nutritionist will have specific recommendations for foods and possibly supplements, but we are able to work with just about any type of diet and occupation.

We sincerely hope you enjoy your progression through the program.

YOU CAN. EXPECT MORE. FROM NATION'S BEST FAMILY HEALTH CARE.

- In the past year, how often have you engaged in physical activity?
 - Regularly (3-4 times/week)
 - Semi regularly (1-2 times/week)
 - Sporadic (1 to 2 times/month)
 - None
- Please explain your current exercise regime or activities performed in the past:
- What is the primary reason for your visit today?

4. What is YOUR primary health concern/illness?

5. What have been your personal barriers for not exercising or following a nutrition program?

6. On a Typical day (MOST OFTEN) what time do you get up and go to bed (___to___)?

7. Facility where you exercise (home or gym) and how long have you been working out?

8. Rate your activity level:

- A. Not very active (go to work and little else)
- B. Moderately active (work and exercise 2-4 days during the week)
- C. Very active (work and at least 1 hour of exercise 5+ days/week)
- D. Competitive (compete in an physically intensive sport)

9. Weight Training Experience:

- A. Have you ever trained with weights before? If so, when, and for how long? What results did you get? Were you satisfied with the results?
- B. Are you currently following any exercise program? If so, what type (i.e. Aerobics, weight training, etc.) and for how long?
- C. Past Fitness Trainers Hired (If Any). Please list who, when, for how long and if you were satisfied with the results?

10. Are you currently on any special diet or nutrition program? Have you tried any specific diets or weight loss programs in the past?

11. What days and times are you available to exercise (at home or a facility)? (3 days minimum)

| DAYS | yes or no | TIMES |
|-------------|------------------|--------------|
| Monday | | |
| Tuesday | | |
| Wednesday | | |
| Thursday | | |
| Friday | | |
| Saturday | | |
| Sunday | | |

12. Alcohol consumption: (x per week, number of drinks and type)?

13. *Specifically* describe what you would like to accomplish overall (mentally and physically)?

14. *Specifically* describe what you would like to accomplish during the next:

A. 1 month:

B. 3 months:

C. 6 months:

15. At what point in your life were you the MOST pleased with your health and appearance?

Current Nutrition Information:

- 1- How would you describe your nutrition overall?

- 2- Describe a typical daily menu from (include snacks and times):

- 3- How much protein do you eat, and what types?

- 4- How many carbs do you eat, and what types?

- 5- How much fat do you eat, and what types?

- 6- Do you like to cook, or do you have time to cook?

- 7- How often do you eat fast food and what types?

- 8- What would you say is your main dietary weakness?

- 9- What foods do you crave the most?

- 10- What foods don't you like AT ALL?

- 11- What do you drink (how much water, sodas, sweet tea, juices)?

- 12- Are you able/willing to take food with you to work?

- 13- Have you ever taken any nutritional supplements? If so, which ones?

- 15- Do you take any supplements now?

- 16-What supplements do you feel have worked for you in the past?

Medical Information:

Please check any recurring symptoms that may affect your nutrition program

General

- Fever
- Chills
- Fatigue
- Weight Loss
- Loss of Appetite

Ear, Nose, Throat

- Sinus problems

Endocrine

- Heat intolerance/ Cold intolerance

Cardiac

- Palpitations
- Chest pain
- Shortness of breath w/ exertion

Respiratory / Chest

- Wheezing
- Difficulty/Pain breathing
- Snoring

Gastrointestinal

- Poor Appetite
- Nausea
- Constipation
- Diarrhea
- Heartburn

Hematology

- Leg or Arm Swelling

Vascular

- Pain in legs after exertion

Musculoskeletal

- Muscle weakness
- Muscle stiffness
- Joint pain
- Joint stiffness

Psychiatric

- Depression/Anxiety
- Difficulty Sleeping

Neurologic

- Numbness/Tingling
- Unsteadiness/Difficulty walking
- Dizziness
- Weakness
- Nerve Pain

| Measurements | |
|--------------|--|
| Shoulders | |
| Chest | |
| Chest/Bust | |
| Abd (Ribs) | |
| Abd (Umb) | |
| Arm (L) | |
| Flexed (L) | |
| Arm (R) | |
| Flexed (R) | |
| Thigh (L) | |
| Thigh (R) | |
| Calf (L) | |
| Calf (R) | |

1. Vitals:

Wt: _____ Lbs. Height: _____ Ft. _____ in. BMI: _____

BP: _____ Pulse: _____ BF% _____