NUTRITION ADVANTAGE, LLC

NAME:_____ DATE:_____

HEALTH DATA

CURRENT HEALTH PROBLEMS/MEDICAL CONDITIONS THAT YOU ARE BEING TREATED FOR: _____

_____

_____

CURRENT MEDICATIONS AND SUPPLEMENTS: List what you are taking and for what indication.

Medication	Indication	Medication	Indication

EXERCISE: _____ none _____ minimal _____ moderate _____ vigorous

Do you have exercise equipment at home? _____ NO _____YES, What kind? _____

_____

Other Info: _____

_____

STRESS LEVEL: _____ Low/Normal _____ Moderate _____ High

Other Info: _____

_____

SLEEP: How many hours on average do you sleep? _____ How would you describe the quality of your sleep? _____

_____

HISTORY OF CIGERETTE USE: _____ Current _____ Former _____ Never

Cigar/Pipe Use: _____ Current _____ Former _____ Never

If Yes: _____Years of smoking _____ Year first started _____ Amount/Packs a day

Year Patient Stopped: _____ Other Info: _____

HISTORY OF ALCOHOL USE: _____ Current _____ Former _____ Never

If Yes: _____Years of drinking _____ Year first started _____ # of drinks a day

Year Patient Stopped: _____ Other Info: _____

GI INFORMATION: Please describe any gastro intestinal concerns that you are currently experiencing:

_____

_____

EATING HABITS, CHECK ANY THAT APPLY TO YOU:

_____ Eating while preparing meals

_____ Eating when not hungry

_____ Eating when too hungry

_____ Eating in response to the clock

_____ Skipping meals

_____ Eating rapidly

_____ Eating unconsciously/mindlessly

_____ Eating past fullness

_____ Binge eating

_____ Eating Secretively

_____ Eating food high in fat or sugar

_____ Eating too much of certain food

_____ Eating late at night

_____ Frequent social/ Restaurant eating

_____ Eating in response to food ads

_____ Eating while reading/watching tv

_____ Eating in rooms besides kitchen

_____ Eating while driving

_____ Eating on the run

_____ Eating more on weekends