



Christina Scribner MS RD CSSD

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PATIENT MEDICAL HISTORY FORM

The following information is very important to your health. Please take the time to fully and completely fill out each page.

Name: _____ DOB: _____ AGE: ____ Gender: _____

Please check one:

Initial _____ I **DO** give Christina Scribner permission to contact me by **e-mail** by EMAIL: ____

Initial _____ I **DO NOT** give Christina Scribner permission to be contacted by **e-mail**.

Initial _____ I **DO** give Christina Scribner permission to leave a confidential message at the following **phone** numbers: Phone: _____

Initial _____ I **DO NOT** give Christina Scribner permission to leave a confidential **phone** message.

Initial _____ I **DO** give Christina Scribner permission to leave a phone **text** message at the following **phone** numbers: Phone: _____

Initial _____ I **DO NOT** give Christina Scribner permission to leave a phone **text** message.

Reason for visit: _____

Any recent diagnostic tests for this problem? _____

Who is your Primary Care Physician? _____

Referred by:

Self Health care provider..... Name? _____

Coach Other..... _____

Why do you want to see the nutritionist? (Check all that apply)

- | | | |
|--|--|--|
| <input type="checkbox"/> General healthy eating advice | <input type="checkbox"/> Sport nutrition advice | <input type="checkbox"/> High cholesterol |
| <input type="checkbox"/> Want to lose weight | <input type="checkbox"/> Vegetarian eating | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Want to gain muscle/weight | <input type="checkbox"/> Disordered eating/eating concerns | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Gastrointestinal problems | <input type="checkbox"/> Food sensitivity/allergy/ intolerance | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Other (please explain): _____ | | |

How long have you had this condition/disease?

Symptoms associated with this condition/disease:

How has your life been effected by your medical condition?

What strengths/skills/personality characteristics do you bring to this problem that will help you overcome it?

Current and Past Medical Treatment: Date or age at time of treatment

Treatment for:	Date:

CURRENT MEDICATIONS:

Medication Dose Frequency Medication Dose Frequency List all medications you are taking:

Medication	Time of Day	Amount	Reason for Taking

SOCIAL HISTORY:

Ethnicity/Race: If bi-racial, or multi-racial please check all that apply:

- African-American
- Arab American
- Asian
- Pacific Islander
- Caucasian, European-American
- Chicano, Latino, Hispanic
- Native American
- Alaskan Native
- Other _____

Religious Affiliation/Spirituality: _____

Is spirituality an important part of health care for you? _____

Do you identify as having a disability? No Yes If Yes, please specify: _____

Are you a parent? No Yes If, Yes, please list the age & gender of your children: _____

STUDENTS ONLY Major: _____

College Class: Freshman Sophomore Junior Senior 5th Year
 Graduate Transfer Student Continuing Education Other: _____

School Status: Full-time Part-time

Housing: Residence: Residence Hall Off-Campus Greek

Secondary School: Freshman Sophomore Junior Senior

Other: _____

Name of School: _____

EMPLOYMENT

Employment: Full-time Part-time Type of Work: _____

Volunteer work: _____

LIVING CONDITIONS:

Current Relationship Status:

Single Married or Partnered Separated Divorced Widowed Other: _____

Who do you live with? Roommate Spouse Children Parents Other _____

Are you satisfied with the living arrangement? Yes No

Explanation: _____

Who shops for food? Self Roommate Spouse Parents Other _____

Who cooks? Self Roommate Spouse Parents Other _____

What types of transportation do you use? Walk Bicycle Skateboard Auto Bus Other _____

PATIENT AND FAMILY MEDICAL HISTORY

PERSONAL Medical History: Place a check mark in front of the conditions you have or have had

<input type="checkbox"/>	Allergies (food)	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	Arthritis
<input type="checkbox"/>	Back Pain	<input type="checkbox"/>	Cancer (type _____)	<input type="checkbox"/>	Constipation
<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	Dental/Chewing
<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	Eating Disorder	<input type="checkbox"/>	Fainting
<input type="checkbox"/>	Food Sensitivities	<input type="checkbox"/>	Fibromalagia	<input type="checkbox"/>	Gastrointestinal
<input type="checkbox"/>	Gallbladder Disorder	<input type="checkbox"/>	Gout	<input type="checkbox"/>	Hair Loss
<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	High Blood Cholesterol	<input type="checkbox"/>	High Blood Triglycerides
<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	Hypoglycemia	<input type="checkbox"/>	Irregular Heart Beat
<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	Migraines
<input type="checkbox"/>	Muscle/Joint	<input type="checkbox"/>	Osteoporosis/osteopenia	<input type="checkbox"/>	Other Allergies
<input type="checkbox"/>	Overweight/Obesity	<input type="checkbox"/>	Polycystic Ovaries	<input type="checkbox"/>	Reflux/Heartburn
<input type="checkbox"/>	Sleep Apnea	<input type="checkbox"/>	Thyroid Problems	<input type="checkbox"/>	Urinary tract infections
<input type="checkbox"/>	Ulcer	<input type="checkbox"/>	Victim of Abuse	<input type="checkbox"/>	Sexually Transmitted
<input type="checkbox"/>	Depression	<input type="checkbox"/>	Anxiety Disorder	<input type="checkbox"/>	Substance Abuse
	Other _____		Other _____		Other _____
Abnormal Labs:				Date of Labs:	

List Any Foods You are Allergic to:
List Any Foods You do not Tolerate (but are not allergic to):
On average, how many hours do you sleep per night/day? <input type="checkbox"/> 3-5 <input type="checkbox"/> 6-7 <input type="checkbox"/> 7-9 <input type="checkbox"/> 10 or more
Do you have any other health conditions that are not listed?

Do you commonly experience any of the following symptoms? (Check all that apply)

- Fatigue/Low energy
- Cold sensitivity
- Loss of appetite
- Light-headedness/dizziness
- Extreme hunger
- Irritability or moodiness
- Frequent illness or injury
- Poor concentration
- Thinking about food, eating, or not eating often

FOR FEMALES ONLY:

- 1) Do you have regular menstrual periods? Y N
- 2) Have you ever lost your period for three months or longer? Y N
- 3) Do you take oral contraceptives? Y N

PHYSICAL ACTIVITY

What time do you generally go to bed? _____ am/pm
 What time do you generally wake-up? _____ am/pm

Please identify your typical level of physical activity:

- Level 1: Activities of Daily Living Only
- Level 2: Activities Equivalent to Walking 2-3 miles/d plus other Activities of Daily Living
- Level 3: Activities Equivalent to Walking ~5-8miles/d plus other Activities of Daily Living
- Level 4: Activities Equivalent to Walking ~10-20 miles/d plus other Activities of Daily Living

Regular weekday physical activities include:

Regular physical activities on weekends includes:

Please identify anything that limits or prevents you from being physically active:

Have you ever felt that your exercise was compulsive and or excessive? Y N

Are you are a student-athlete? Y N

- Intercollegiate Team; (Please specify which team: _____)
- High School Team; (Please specify which team: _____)
- Intramural Team (Please specify which team: _____)
- Collegiate Club (Please specify which team: _____)

List any exercise/activity that you do on a regular basis:

Type of activity:	Frequency (days/week):	Duration (length of workout):	Intensity (light, moderate, high):

Quality of Life:

Please evaluate the following

How would you describe your personality Type?

- Impatient Time-oriented Competitive
 Usually somewhat relaxed Sometimes anxious Relaxed and easy going

Stress Level..... Low Moderate Severe

Major Sources of Stress _____

Do practice stress-reduction techniques? No Yes If yes, please describe: _____

Quality of Social Life V. Poor Poor Adequate Good Excellent

Quality of Mental Health..... V. Poor Poor Adequate Good Excellent

Quality of Physical Health..... V. Poor Poor Adequate Good Excellent

Do you have a support system? No Yes Who? _____

BODY WEIGHT

What is your current body weight? _____

What is your current body height? _____

How long have you been at your current weight? _____

Lowest adult weight: _____ lbs When? ____/____ (month/year)

Highest adult weight: _____ lbs When? ____/____ (month/year)

Are you satisfied with your body weight and shape? Y N

If not, what change(s) would you like?

Frequency of Weighing Self:

- multiple times per day once daily once weekly infrequently varies based on moods

Have you ever tried to lose weight? No Yes

Types of weight management used in the PAST:

- Restriction/Diets Skipping Meals Vomiting Chewing and Spitting Laxatives
 Diet Pills Exercise

Types of weight management used NOW:

- Restriction/Diets Skipping Meals Vomiting Chewing and Spitting
 Laxatives Diet Pills Exercise

Do you believe any of these methods are successful methods of weight management for you?

- No Yes

EATING PATTERN

Where do you eat most of your meals? (Check all that apply)

- Self-Preparation
 Residence Hall
 Campus Convenience Store
 Student Center (please specify: _____)
 Restaurants (please specify _____)
 Other (please specify: _____)

How many times per day (meals + snacks) do you eat? 1-2 3-4 5-6 6-8 9+

How many days per week do you eat "breakfast"? 1-2 3-4 5-6 6-7

What time do you generally eat your largest meal?

morning noon mid-afternoon late afternoon evening

What meal is most frequently skipped? morning noon evening

Do you follow any special diet or food pattern (e.g. low-fat, vegetarian, religious guidelines)?

Y N

If yes, please describe: _____

Do you usually go to bed feeling hungry? Y N

Do you usually go to bed feeling overly full? Y N

Does your eating or weight feel out of control? Y N

Do you consciously limit or avoid any of the following foods: (Check all that apply)

Red meat Milk Sweets Butter/margarine

Chicken Cheese Grains (i.e. rice, pasta) Other(s) – please list:

Seafood Oils/dressings Breads

Turkey Vegetables Fast food

How many servings of fruit do you eat per day? 0 to 1 2 to 3 4 to 5 > 5
(ONE SERVING = 1 tennis ball sized piece of fruit OR 1 cup chopped fruit OR ½ cup (4 oz) 100% fruit juice)

How many servings of vegetables do you eat per day? 0 to 1 2 to 3 4 to 5 > 5
(ONE SERVING = ½ cup cooked vegetables OR 1 cup raw vegetables OR ½ cup (4 oz) vegetable juice)

How many servings of proteins do you eat per day
(ONE SERVING = meat, poultry, or fish the size of a deck of cards; 2 Tablespoons nuts or nut butter, 1-2 eggs, ½ cup beans such as pinto, garbanzo, black, refried) 0 to 1 2 to 3 4 to 5 > 5

How many servings of calcium-rich dairy foods do you eat per day
(ONE SERVING = 1 c (8 oz) milk, soy milk, goat's milk or 1. c yogurt, 1 ½ oz natural cheese, processed cheese, 2 c cottage cheese, 1 c pudding, 1 ½ cu ice cream or frozen yogurt) 0 to 1 2 to 3 4 to 5

How many days per week do you eat cookies, cakes, pies, candy 0 to 1 2 to 3 4 to 5 6-7

How many days per week do you eat fast foods 0 to 1 2 to 3 4 to 5 6-7

How many days per week do you eat fried foods, snack chips 0 to 1 2 to 3 4 to 5 6-7

Q: How many days per week do you eat high fat meats and high fat dairy (e.g., hot dogs, sausage, whole milk, whole milk cheese) 0 to 1 2 to 3 4 to 5 6-7

Q: Approximately how many cups of fluid (all beverages including milk, juice and broth-type soups) do you consume each day? < 2 cups (less than 16 oz) 2 to 4 cups (16-32 oz) 5-6 cups (40-48oz) 7-8 cups (56-64 oz)

How much reluctance do you feel about coming in for nutrition counseling?

- No reluctance at all
- Very little reluctance
- Some reluctance
- Quite a bit of reluctance
- Strong reluctance

Please explain:

What do you hope to achieve as a result of nutrition counseling?

Rate how important this change is to you (0 not at all, 10 extremely):

0 1 2 3 4 5 6 7 8 9 10

Rate how confident you are to make this change at this time:

0 1 2 3 4 5 6 7 8 9 10

What barriers, if any, stand in the way of you achieving your nutritional goals?

Do you have an interest in seeing a psychotherapist? Y N

I have access to a copy of Christina Scribner's Privacy Policy Practices

Y Initial_____ N Initial_____

This information I give to the best of my knowledge:

Client's Signature: _____

Date: _____

Reviewed by: _____ Date: _____ (REV. 1/2010)