***Christina Scribner MS RD CSSD***

• Registered Dietitian • Board Certified Specialist in Sports Dietetics•

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**PATIENT MEDICAL HISTORY FORM**

The following information is very important to your health.

Name:      DOB:     \_\_\_\_\_\_AGE:      \_Gender: □ F □ M

**Initial\_ \_**□ I **DO** give Christina Scribner permission to contact me by **e-mail** by. EMAIL:     

**Initial\_ \_**□ I **DO NOT** give Christina Scribner permission to contacted me 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**:

Why do you want to see a nutritionist?

Any recent diagnostic tests for this concern?

Who is your Primary Care Physician?

Who referred you for treatment?

How long have you had this condition/disease?

Symptoms associated with this condition/disease:

How has your life been affected by your medical condition?

**History**

**Anthropometrics**

**BODY WEIGHT**

What is your current body weight?     

What is your current body height?

Approximately how long have you been at your current weight?

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

Highest (adult) weight:\_     lbs   When?       (month/year)

Describe circumstances related to weight change

What do you consider to be your “best” weight?     Why?

**Biochemical**

|  |  |
| --- | --- |
| Recent Abnormal Labs | Date of Labs: |

**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 and nutritional supplements you are taking:

|  |  |  |  |
| --- | --- | --- | --- |
| Medication | Time of Day | Amount | Reason for Taking |
|  |  |  |  |
|  |  |  |  |
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**Functional**

**SLEEP**

What time do you generally go to bed? \_\_\_\_am/pm

What time do you generally wake‐up? \_\_\_\_ am/pm

On average, how many hours do you sleep per night/day?   
 3-5       6-7        8-9       10 or more   
  
Is your sleep disrupted during the night? Y          N

Do you believe your sleep is adequate?     Y           N

**PHYSICAL ACTIVITY**

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:

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

Regular physical activities on weekends includes:      

What types of transportation do you use? □ Walk □ Bicycle □ Skateboard □ Auto □ Bus □ Other \_

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**

**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? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What strengths/skills/personality characteristics do you have or do other people see in you to overcome problems?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you see a psychotherapist? **Y****N**   If yes, who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If no, do you have an interest in seeing a psychotherapist? **Y****N** 

**PATIENT AND FAMILY MEDICAL HISTORY**

**Please identify the conditions you or a family member has had.**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | Current | Past | Family Member |  | Current | Past | Family Member |
| Allergies to Food |  |  |  | Anemia |  |  |  |
| Arthritis |  |  |  | Back Pain |  |  |  |
| Constipation |  |  |  | Cancer (type \_\_\_\_\_\_\_\_) |  |  |  |
| Diabetes |  |  |  | Diarrhea |  |  |  |
| Dental/Chewing |  |  |  | Gastrointestinal |  |  |  |
| Depression |  |  |  | Anxiety Disorder |  |  |  |
| Eating Disorder |  |  |  | Fainting |  |  |  |
| Food Sensitivities |  |  |  | Fibromyalgia |  |  |  |
| Gallbladder Disorder |  |  |  | Gout |  |  |  |
| Hair Loss |  |  |  | High Blood Triglycerides |  |  |  |
| High Blood Pressure |  |  |  | High Blood Cholesterol |  |  |  |
| Heart Disease |  |  |  | Hypoglycemia |  |  |  |
| Rapid Heart Beat |  |  |  | Slow Heart Beat |  |  |  |
| Kidney Disease |  |  |  | Liver Disease |  |  |  |
| Migraines |  |  |  | Muscle/Joint |  |  |  |
| Non-food Allergies |  |  |  | Osteoporosis/osteopenia |  |  |  |
| Overweight/Obesity |  |  |  | Polycystic Ovaries |  |  |  |
| Sleep Apnea |  |  |  | Sexually Transmitted |  |  |  |
| Substance Abuse |  |  |  |  |  |  |  |
| Thyroid Problems |  |  |  | Urinary tract infections |  |  |  |
| Ulcer |  |  |  | Victim of Abuse |  |  |  |
| Other |  |  |  | Other |  |  |  |

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:**Age of first menses \_\_\_\_\_\_\_  
Do you have regular menstrual periods now?      **Y****N**    
Date of last menstrual period \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_          
Have you ever lost your period for three months or longer?   **Y****N**    
Are you sexually active? **Y****N**    
Do you take oral hormones for contraception? **Y****N**    
Other method of contraception or “safe sex”? \_\_\_\_\_\_\_\_\_\_\_

**BODY IMAGE**

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

**WEIGHT MANAGEMENT**

Have you ever tried to lose weight? No  Yes

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

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

No Yes

**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 *or* religion an important part of health care for you? □ No □ Yes

### Do you identify as having a disability? □ No □ Yes If Yes, please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

### STUDENTS ONLY Major: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**High School Class:** □Freshman □Sophomore □Junior □Senior

**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:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you are a student‐athlete? **Y****N**    
          
 Intercollegiate or Intramural Team; (Please specify which team:

School Team; (Please specify which team:

**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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Do you have siblings that live in the same household with you? □ No □ Yes   
 If, Yes, please list the age & gender of your siblings: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Sexual Orientation (choose all that apply):**

1. \_\_ asexual
2. \_\_ bisexual
3. \_\_ gay
4. \_\_ straight (heterosexual)
5. \_\_ lesbian
6. \_\_ pansexual
7. \_\_ queer
8. \_\_ questioning or unsure
9. \_\_ same gender loving
10. \_\_ an identity not listed: please specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
11. \_\_ prefer not to disclose

**Gender identity (choose all that apply):**

1. \_\_ agender
2. \_\_ androgyne
3. \_\_ demi-gender
4. \_\_ gender queer or gender fluid
5. \_\_ male
6. \_\_ questioning or unsure
7. \_\_ trans man
8. \_\_ trans woman
9. \_\_ female
10. \_\_ additional gender category/identity: please specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
11. \_\_ prefer not to disclose

**Recreational substance use may affect nutrition:**

1. Do you drink alcoholic beverages?    **Y****N**    
    How many days per week do you use Beer or Wine?
   * 1. 0 to 1        2 to 3         4 to 5        6-7

How many days per week do you use Hard Liquor?   
   
  0 to 1        2 to 3         4 to 5        6-7

|  |  |  |  |
| --- | --- | --- | --- |
|  | Current | Past | Details on Frequency |
| Tobacco (Cigarette, Pipe, Cigar, Chewing Tobacco) |  |  |  |
| Marijuana |  |  |  |
| Cocaine |  |  |  |
| Ecstasy |  |  |  |
| Acid |  |  |  |
| Mushrooms |  |  |  |
| Steroids or Pro-hormones |  |  |  |
| Prescription Drugs used without Prescription please specify |  |  |  |

**Caffeine Intake:**  
Do you drink caffeinated beverages (i.e. coffee, tea, soda)?   **Y** **N**What times of day? \_\_\_\_\_\_\_\_\_\_\_\_\_Amount daily?\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Dietary**

**EATING PATTERN**

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

Self

Home (with family)

With friends and others (please specify:\_\_\_**\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_)

Residence Hall or Cafeteria

Campus Convenience Store

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:\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who shops for food? □ Self □ Roommate □ Spouse □ Parents □ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Who cooks? □ Self □ Roommate □ Spouse □ Parents □ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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)

|  |  |  |  |
| --- | --- | --- | --- |
|  |  | |  |
| 1. Red meat | 1. Milk | 1. Sweets | 1. Butter/margarine |
| 1. Chicken | 1. Cheese | Grains (i.e. rice, pasta) | 1. Other(s) – please list: |
| 1. Seafood | Oils/dressings | 1. Breads |  |
| 1. Turkey | 1. Vegetables | 1. 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

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

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)  9 cups or more

**TYPICAL DIETARY INTAKE:**

**Please fill in the following table with an example of what you *typically* eat**

|  |  |  |
| --- | --- | --- |
| **Time** | **Food Eaten** | **Where/With Whom** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
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|  |  |  |
|  |  |  |

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? 

Please feel free to share any other information that you think would be helpful to know in caring for you:

I have seen and have access to a copy of Encompass Nutrition / Christina Scribner’s Privacy Policy Practices   
 **Y**Initial\_**N** Initial\_

This information I give to the best of my knowledge:

Client Signature:       Date:

Responsible Parent Signature:      Date:

Provider Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(REV. 2018)