NEW CLIENT INFORMATION FORM

Today's date: ______________________

Name: ______________________________ DOB: _________________

Address: ____

Email: ______________________________________

Phone: _______________

Emergency contact/relationship: __________________________________

Phone: _______________

Preferred pronouns:______________________________________

Height: _____________________________ Current weight: ______________________

Highest weight/date: __________________ Lowest weight/date: _______________

TREATMENT TEAM			
Name	**Specialty**	**Date of first consultation / treatment**	**Duration** (if still seeing, write 'present')

CURRENT MEDICATIONS				
Name	**Reason**	**Frequency**	**Dosage**	**Result**

Are you taking all medications consistently as prescribed? _____________________

CURRENT SUPPLEMENTS OR ALTERNATIVE THERAPIES				
Name	**Reason**	**Frequency**	**Dosage**	**Result**

PREVIOUS HOSPITALIZATIONS, SERIOUS ILLNESSES, HEALTH PROBLEMS	
Description	**Date**

Have you ever been diagnosed with any of the following?

Acid reflux	Depression	Lactose intolerance
Alcohol abuse	Diabetes, type 1	Liver disease
Anemia	Diabetes, type 2	OCD
Anxiety	Heart disease	Sleep apnea
Arthritis	High blood pressure	Substance abuse
Asthma	High cholesterol	Trauma/PTSD
Cancer	High triglycerides	Ulcerative colitis
Celiac disease	Hyperthyroid	Other: _____________
Chrohn’s disease	Hypothyroid	Other: _____________

Are you concerned about any of the following?

Anorexia	Emotional overeating	Orthorexia
Binge eating	Food restriction	Overeating
Body image	Food sensitivities	Overexercise
Bulimia	Laxative use	Purging

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Do you use any of the following?

Alcohol	Cigarettes/nicotine	Laxatives
Artificial sweeteners	Condiments	Opiates
Caffeine	Diet soda	Pain killers
Cannabis/marijuana	Gum	Stimulants

Type/quantity/frequency/other:

____

____

____

Do any of the following affect disordered eating behaviors:

Presence of specific foods:

____

____

Specific people:

____

____

Times of day:

____

____

Situations or locations:

____

____

Relevant disordered eating milestones:

____

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Have you ever had a bone fracture, stress fracture, or overuse injury?

Menstrual history (if applicable):

Age at first period: ______________ Are your periods regular: ______________________

Do your periods affect your mood and/or eating:

If peri-menopausal, at what age did peri-menopause begin: __________________________

If post-menopausal, at what age did menopause begin: _____________________________

Any family medical history you think I should know about (physical, mental, substance abuse, eating disorder)?

Food Restrictions (allergies, intolerances, dislikes, sensitivities, philosophical reasons, etc.)

____

____

____

How is your sleep? (amount, any problems, etc.)

____

____

____

What is your relationship with exercise? (types, amount, frequency, concerns, etc.)

____

____

____

How do you manage stress?

____

____

____

Is spirituality a part of your life?

____

____

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Who is in your support network?

What is your most pressing concern today?