Client History Form

Name: _____ Today's Date: _____
Address (street): _____ Date of last medical checkup: _____
Address (city, zip): _____ Birthdate and Age: _____
Daytime Phone: _____ Gender: _____
Evening Phone: _____ Height: _____
Email Address: _____ Weight: _____
Explain your personal goal(s) and expectations in working with a dietitian:

Health History

1. Have you been told that **you** have (check all that apply):

☐ Diabetes	☐ Heart Disease	☐ Cancer
☐ GI Disorders	☐ Lung Disease	☐ Arthritis
☐ High Bood Pressure	☐ Liver Disease	☐ High Cholesterol
☐ Hardening of Arteries	☐ Ulcers	☐ Other

2. Do you have any complaints of the following:

☐ Lack of appetite	☐ Diarrhea	☐ Nausea
☐ Difficulty chewing/swallowing	☐ Indigestion	☐ Vomiting
☐ Constipation	☐ Asthma	☐ Other

3. For Females:
   Are you pregnant? ☐ Yes ☐ No If Yes, how many months: _____
   Is menstruation normal? ☐ Yes ☐ No If No, explain _____
4. Do you smoke? ☐ Yes ☐ No If Yes, how long:

Socioeconomic History

1. Occupation: _____
2. Do you grocery shop? Where? _____
3. How often do you dine out? _____

Drug/Supplement History

1. List all medications and supplements you take, either prescribed or over-the-counter?

Name of drug/supplement	Reason	Frequency

2. Explain any side effects you have noticed any side effects from taking these medications/supplements?

Exercise History

1. Are you currently participating in a structured cardiovascular program? _____
2. Are you currently participating in a structured resistance training program? _____
3. How often do you exercise? _____
4. I you answered no to the above questions,
   when was the last time to particpated in an exercise program? _____

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