

NEW CLIENT REGISTRATION

Client Information

Name: _____ M / F			Date: _____		
Home Address: _____		City: _____	DOB: _____	Age: _____	
Cell Phone: _____		Home Phone: _____			
Email Address: _____					
Employer: _____			Work Phone: _____		

Primary Care Doctor

Name: _____	Phone #: _____
Address: _____	

Specialist (type):

Name: _____	Phone #: _____
Address: _____	

Specialist (type):

Name: _____	Phone #: _____
Address: _____	

Therapist (if applicable)

Name: _____	Phone #: _____
Address: _____	

Weight Information:

Height: _____	Weight: _____	Average weight last 2 years: _____	
Weight you would like to weigh: _____		Last age at that weight: _____	
Highest Adult Weight: _____	Age: _____	Lowest Adult Weight: _____	Age: _____
Pre-Pregnancy Weight: _____		How much weight gain during pregnancy? _____	
Have you lost or gained weight recently? _____		How Much? _____	Time Frame? _____
How often do you weigh yourself? _____		Last complete physical exam? _____	
Check off how you currently feel about your body: <input type="checkbox"/> Strongly Dislike <input type="checkbox"/> Dislike <input type="checkbox"/> Slightly Satisfied <input type="checkbox"/> Satisfied <input type="checkbox"/> Very Satisfied			

Nutritional Concerns:

Reason For Consultation: _____			
Referred By: _____			
Current Conditions	Nutritional Concerns	Symptoms	Other Pertinent Conditions
<input type="checkbox"/> Cancer (type) _____ <input type="checkbox"/> Celiac Disease <input type="checkbox"/> Crohns Disease <input type="checkbox"/> Diverticulitis / Diverticulosis <input type="checkbox"/> Diabetes <input type="checkbox"/> Food Allergies _____ <input type="checkbox"/> Heart Disease <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> High Cholesterol <input type="checkbox"/> High Triglycerides <input type="checkbox"/> Hypo / Hyperglycemia <input type="checkbox"/> Hypo / Hyperthyroid <input type="checkbox"/> Irritable Bowel Disease <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Weight Gain <input type="checkbox"/> Weight Loss <input type="checkbox"/> Other _____ <input type="checkbox"/> Other _____	<input type="checkbox"/> Anemia <input type="checkbox"/> Celiac / Gluten Sensitivity <input type="checkbox"/> Diabetes <input type="checkbox"/> Digestive Problems <input type="checkbox"/> Food Allergies <input type="checkbox"/> Headaches / Migraines <input type="checkbox"/> Heart Health <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Hypo / Hyperglycemia <input type="checkbox"/> Lactose Intolerant <input type="checkbox"/> Low Energy <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Thyroid <input type="checkbox"/> Weight Loss <input type="checkbox"/> Other _____ <input type="checkbox"/> Other _____	<input type="checkbox"/> Anemic <input type="checkbox"/> Bloating <input type="checkbox"/> Constipation <input type="checkbox"/> Decreased Appetite <input type="checkbox"/> Depression <input type="checkbox"/> Diarrhea <input type="checkbox"/> Excessive Appetite <input type="checkbox"/> Excessive Gas <input type="checkbox"/> Headache / Migraine <input type="checkbox"/> Low Energy / Fatigue <input type="checkbox"/> Mood Swings <input type="checkbox"/> Sensitive to Foods <input type="checkbox"/> Shaky or Irritable if Hungry <input type="checkbox"/> Weight Gain <input type="checkbox"/> Weight Loss <input type="checkbox"/> Other _____ <input type="checkbox"/> Other _____	List all known food allergies, if Applicable and other conditions not listed on this form: _____ _____ _____ _____ _____ _____ _____

Nutritional / Dietary History

Medications currently taking (list names, conditions and dosages):
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Supplements currently taking (list names and dosages):

Have you ever followed a special diet or taken any special diet products in the past? Yes No

Please check off below if you have been on or tried any of the following weight-loss aids / plans:

<input type="checkbox"/> Appetite Suppressants	<input type="checkbox"/> Low Calorie	<input type="checkbox"/> Liquid Diet	<input type="checkbox"/> Lindora
<input type="checkbox"/> Carb / Fat Blockers	<input type="checkbox"/> Low Carb	<input type="checkbox"/> Vegetarian	<input type="checkbox"/> Weight Watchers
<input type="checkbox"/> Metabolic Enhancers	<input type="checkbox"/> Low Fat	<input type="checkbox"/> Jenny Craig	<input type="checkbox"/> Other

Nutrition Habits:

How many meals do you eat per day?	If you skip meals, what meal/s?
How many snacks do you eat per day?	What is a typical snack?
What time is your last meal or snack?	How many sodas/day? Per Week? <input type="checkbox"/> Regular <input type="checkbox"/> Diet
Do you have sugar cravings?	How many sweets/day? Per Week? Type?
How many ounces of water do you drink per day?	Number of caffeinated drinks per day? Type?
What other beverages do you drink? <input type="checkbox"/> Milk <input type="checkbox"/> Tea <input type="checkbox"/> Juice <input type="checkbox"/> Soda <input type="checkbox"/> Lemonade <input type="checkbox"/> Other Sweetened Drinks	
Do you tend to eat low fat or non-fat foods? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you avoid fats with your meals? <input type="checkbox"/> Yes <input type="checkbox"/> No
Do you eat processed foods regularly? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you eat fast food regularly? <input type="checkbox"/> Yes <input type="checkbox"/> No
How many meals per week do you eat fast food?	Do you out at a restaurant regularly? <input type="checkbox"/> Yes <input type="checkbox"/> No
How many meals per week do you eat at a restaurant?	Which restaurants?
Do you tend to rush when eating? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you eat due to emotions? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, which emotions?	Do you feel out of control with certain foods? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, which foods?	
Have you ever been diagnosed with an eating disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, please describe any and all treatment:	
Name two healthy qualities about your present diet:	
List some dietary changes you would like to focus on:	

Social Information / Other:

Occupation:	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed
Who prepares your meals?	Who does the shopping?
How many people in your family?	What stores do you shop at?
Age of children?	Hobbies?
Ability to sleep? <input type="checkbox"/> No problem <input type="checkbox"/> Needs Improvement <input type="checkbox"/> Poor	Number of hours sleep/night?
Stress: <input type="checkbox"/> Low <input type="checkbox"/> Moderate <input type="checkbox"/> High	Stress: <input type="checkbox"/> Manage well <input type="checkbox"/> Need help managing
Do you smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, how much?
Do you drink? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, how much?
Do you exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, indicate type and frequency below:
Cardio:	
Resistance:	
Do you have any medical condition that would prevent you from exercising? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, name the condition:	

Our programs ARE NOT DIETS; they require a commitment to a lifestyle change. Because we only choose to work with committed clients, there is no refund if you are unable or unwilling to follow our recommendations. Pre-purchased sessions will expire 1 year from date of purchase. A 24-hour notice of cancellation is required to avoid being charged for the session.

WAIVER

I, the undersigned, have read, understand, and have answered the above health/medical survey questions fully and truthfully. I am aware of my responsibility to consult with my personal physician regarding my clearance to engage in any nutritional support program. I do hereby intend to be legally bound for myself and waive release of any and all rights and claims for damages I may have against Healthy Fit Nutrition, Inc. and Newport Nutrition and its dietitian administering this program, as well as the program creators themselves or anyone in connection with them, for any and all injuries suffered while following the nutritional program provided for me. I also understand and agree to the no refund policy stated above.

Client Signature: _____

Date: _____

Print Client Name: _____