DIETITIAN PATIENT INTAKE FORM

Kathleen Litzenberger
Registered Dietitian

PATIENT INFORMATION		
First Name:	Last Name:	
Address:	City:	Postal Code:
Cell Phone:	Work/Home Phone:	
Email (I agree to receive appointment reminders and clinic updates):		
Birthday (dd/mm/yr):	Gender (M/F/other):	
Is there any other way you would like or prefer to identify? (e.g. first nations, métis, gender, pronous, cultural, ethnic, racial):		
Occupation:	Marital Status:	
Family Doctor:	Date of last check up with doctor/blood work:	
Alberta Health Care Number:		

Extended Health Care Coverage

Insurance Company Name:	
Group ID/Policy Number:	Member Number:
Relationship to Cardholder (self/spouse/child):	
Name of Cardholder:	

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PERSONAL HEALTH QUESTIONNAIRE

Please list any **main health goals/lifestyle/objectives/concerns** you may have and/or **reason for referral:**

Height: Current Weight: Goal Weight:

Have you **lost/gained weight** in the **past 6 months** *without* trying to lose/gain this weight? If yes, how much?

Have you been eating less than usual for *more than* 1 week? YES/NO

MEDICAL HISTORY

Please list current medications and supplements you are taking:
(i.e. prescription and over-the-counter medication, vitamins, minerals, herbs, or other homeopathics)

Medication/Supplement Brand	Daily Dose	Taking for how long?

Please indicate any allergies and/or food sensitivities:

Allergy/Food Sensitivity/Intolerance	Symptoms/Reaction

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Please indicate whether *you* or *your immediate family members* have or have had the following:

Condition	Who?	Condition	Who?
Alcoholism		Lactose Intolerance	
Anemia/Iron deficiency		Liver Disease	
Arthritis		Osteoporosis	
Cancer Type:		Parkinsons	
Celiac Disease:		Pregnancy	
Cholesterol (High or Low): High Triglycerides:		Rheumatoid Arthritis	
Colitis:		Shortness of breath	
Crohn's:		Sleep Apnea	
Depression:		Other:	
Diabetes Type 1 or Type 2:			
Gallstones			
Gout			
Heart Disease			
Heart Burn/Reflux			
Hypertension (High Blood Pressure)			
IBS (Irritable Bowel Sydrome)			
Kidney Stones			
Lactation (Breastfeeding)			