Date:

ID:
Name:
DOB:

TKS Nutrition, LLC
Healthy Habits for LIFE

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Demographic Information

Please enter your current details in the fields below:

How did you hear of us?

Reason for visit:

Treatments tried:

Date of birth:
Social Security Number:

Address: City:
State: Zip code:
Primary phone number:
Secondary phone number
Email address:

Preferred contact method/s: Email- No Yes Phone- No Yes
Can we leave a message: Yes No

Emergency contact: _____ **Phone:** _____

Marital status:
Highest level of education:
Occupation:
Work hours:
Members of household:

General Health Information

Please enter your insurance details, primary care physician and other important healthcare providers:

Primary insurance name:
Type of plan: **Phone number:**
Insured's name: **DOB:**
Relationship:
Specialist co-pay: $
Membership ID number: **Group ID number**

Secondary insurance name:
Type of plan: **Phone number:**
Insured's name: **DOB:**
Relationship:
Specialist co-pay: $
Membership ID number: **Group ID number:**

Primary physician name: **Phone number:**
Address:
Date of last physical:
Date of last blood test:
Other important healthcare providers name and phone number:

Family History

Do you have a family history of the following? Please check all that apply.

No Yes - Cancer	**No Yes** - High blood cholesterol	**No Yes** - Liver disease
No Yes - Diabetes	**No Yes** - High blood pressure	**No Yes** - Thyroid disease
No Yes - Heart disease	**No Yes** - Kidney disease	**No Yes** - Obesity

Other family medical history:

Medical History

Please select if you have been diagnosed with or currently have, any of the following medical conditions:

No Yes - Alcohol abuse	**No Yes** - Falls	**No Yes** - Liver disease Details:
No Yes - Anemia	**No Yes** - Fibromyalgia	**No Yes** - Lung disease Details:
No Yes - Anxiety or panic attacks	**No Yes** - Gallbladder disease / gallstones	**No Yes** - Metabolic syndrome
No Yes - Arthritis	**No Yes** - Gout	**No Yes** - Memory problems Details:
No Yes - Asthma	**No Yes** - Hearing problems	**No Yes** - Myocardial infarction / angina
No Yes - Autoimmune condition	**No Yes** - Headaches / migraines	**No Yes** - Osteoporosis / osteopenia
No Yes - Back pain	**No Yes** - Hay fever	**No Yes** - PMS
No Yes - Bronchitis	**No Yes** - Heartburn	**No Yes** - Polycystic ovary syndrome
No Yes - Cancer Type:	**No Yes** - Heart disease Details:	**No Yes** - Pneumonia
No Yes - Depression	**No Yes** - Hemorrhoids	**No Yes** - Pre-diabetes
No Yes - Diabetes Type:	**No Yes** - Hepatitis	**No Yes** - Prostate problems
No Yes - Drug abuse	**No Yes** - High cholesterol levels	**No Yes** - Psychiatric conditions Details:
No Yes - Diverticulitis	**No Yes** - Hypertension (high blood pressure)	**No Yes** - Sinusitis

No Yes - Dry itchy skin, rashes, dermatitis	**No Yes** - HIV/AIDS	**No Yes** - Sleep apnea
No Yes - Eating disorder Details:	**No Yes** - IBD (Crohn's or ulcerative colitis)	**No Yes** - Stomach ulcers
No Yes - Eczema	**No Yes** - Irritable bowel syndrome (IBS)	**No Yes** - Stroke
No Yes - Epilepsy, convulsions, seizures	**No Yes** - Joint pain / joint replacement Details:	**No Yes** -Thyroid disease / condition Details:
No Yes - Erectile dysfunction	**No Yes** - Kidney disease Details:	**No Yes** - Urinary tract infection
No Yes - Eye disease Details:	**No Yes** - Kidney stones	**No Yes** - Vitamin D deficiency

Other medical conditions:

Allergies (medication / food/ enviornmental):

Food Intolerances:

Past surgeries / hospitalizations:

Current health (rating): Excellent Good Fair Poor

Females Only

If you are female, please answer the following questions.

Currently pregnant: Yes No **Due date:**
Previous pregnancies: Yes No **Details:**
Currently lactating: Yes No **Duration:**
Age at first period:
Irregular periods: Yes No **Details:**
Oral contraceptive use: Yes No **Details:**

Medication & Supplements

Please list all prescription and over-the-counter medications, vitamin, mineral and nutritional supplements, herbs/botanicals and diet aids you are currently taking.

Name of Medication / Supplement	Reason	Dose & Frequency

Lab Results

Please enter your most recent lab results below:

Lab results:

Blood pressure: _____/_____

Diagnostic studies:

Weight History

Please enter your current weight and height as well as information about what your weight was like in the past.

Estimated weight:

Height: _____ft ____in (in)

Recent weight gain: No Yes **Amount:** **Time:**

Recent weight loss: No Yes **Amount:** **Time:**

Lowest adult weight: **Age:**

Highest adult weight: **Age:**

Physical Activity

Do you regularly participate in physical activity/exercise? If the answer is yes, please describe below. If you are unable to exercise, please provide details.

Regular physical activity / exercise: Yes No **Type:**

Session duration:

Frequency:

Barriers to exercising: Yes No **Details:**

Screen Time: which includes TV, computer, video gaming & texting (number of hours daily):

Daily Habits

Please describe below your food, water, caffeine and alcohol intake, smoking status, recreational drug use.

Food Habits

1. On most days, how many meals do you eat?

_____ per day **1a**. Snacks? _____ per day

2. How many of those meals are usually prepared by you or someone in your household?

_____ per day

3. How many meals per **week** do you usually eat out? Count meals prepared by a commercial food service, restaurant, deli or fast food provider.

_____ per week

Breakfast: ____ Lunch:_____ Dinner: _____

4. Breakfast - How often do you eat breakfast?

① everyday
② most days
③ some days
④ rarely or never

5. Skip meals - How often do you skip a meal?

① everyday
② most days
③ some days
④ rarely or never

6. Night eating - How often do you eat a meal or snack less than 2 hours before bedtime?

① everyday
② most days
③ some days
④ rarely or never

7. Appetite – How do you rate your appetite or desire for food?

① very good
② good
③ not always good
④ poor most of the time

8. Satisfied - How often do you stop eating after you feel you have eaten enough?

① always
② most of the time
③ some of the time
④ rarely or never

9. Binging, is to lose control by eating a large amount of food over a short period of time. Do you ever binge?

Yes No If yes, how many times per week? _____ per week

10. Water - Think about what you drink all during the day. How many cups (8 oz cup) of water or other non-caffienated beverages such as juice do you have on most days (do not count tea, coffee, beer or other alcoholic beverages)?

_____ per day

11. How many **caffeinated beverages** do you drink each day? Please include regular tea, coffee, espressos, lattes, or caffeinated soft drinks.

_____ per day Type: _____

12. Alcohol - Have you had any alcoholic beverages in the last 6 months? Yes No

13. How many drinks of beer, wine or Liquor do you regularly have per **week**? (one drink is 3 to 5 oz. wine, 10 oz wine cooler, 12 oz beer or 1.5 oz liquor)

_____ drinks per week

14. Milk preferences - Which statement best describes the fat content of milk you would choose to drink?

① Only regular whole milk (about 4% fat)
② Both regular whole milk and low fat milk
③ Only low-fat milk (1 to 2 % fat)
④ Both low-fat and non-fat milk
⑤ Only non-fat milk (0.5% fat)
⑥ Do not drink dairy milk
⑦ Do not drink dairy milk but use fortified dairy alternates such as 1% soy, rice or almond milk

15. Fat preferences - When choosing foods for your meal, do you usually select, high-fat or low-fat foods? After reviewing the examples, select the most appropriate response.

High-fat examples: hamburgers, sausages, luncheon meat, marbled beef, sour cream, cheese, eggs, butter, pastry, ice cream, full-fat dairy products, chocolate, fried foods and many fast foods

Low-fat examples: lean meats, skinless poultry, fish, low-fat dairy products, fruit desserts, gelatin, vegetables, pasta, and legumes (peas and beans)

① choose high-fat foods nearly all the time
② choose high-fat foods most of the time
③ choose both high and low-fat foods equally as often
④ choose low-fat foods most of the time
⑤ choose low-fat foods all the time

16. Added salt - How often do you add salt to your food?
① not at all
② occasionally (2 – 3 times per week)
③ moderately (one meal per day)
④ quite often (nearly every meal)
⑤ Majority of the time (on most everything)

17. Salty food - How often do you eat salty foods (such as soy sauce, pickles, canned meats, salted nuts or potato or corn chips)?
① not at all
② occasionally
③ moderately
④ quite often
⑤ majority of the time

18. Fiber preferences How often do you choose to eat high-fiber foods such as whole wheat bread or pasta, high-fiber breakfast cereal and brown rice?

① rarely or never
② occasionally
③ sometimes
④ majority of the time
⑤ always

Who is the primary food shopper? _____

How frequently do you food shop per week? _____ per month? _____

Where do you usually shop for food? _____

Who usually prepares and cooks your meals? _____

Where do you usually eat your meals (kitchen tale, front of TV, bed, desk, car, etc):

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Current smoking status: Yes No
Amount: _____ per day
Past smoking status: Yes No
Amount: _____ per day

Regular recreational drug use: Yes No
Problems with alcohol or drug abuse: Yes No
Received treatment for substance abuse: Yes No **Details:**

Stress

On a scale from 1-10 with 10 being the highest, how would you rate your daily level of stress? _____

Stress rating (0 = no stress & 10 = extreme stress): Details:

Sleep

Based on your sleep habits during the past month only, how many hours of sleep, on average, do you get on weeknights and weekend nights?

Amount of sleep on week nights:
Amount of sleep on weekend nights:

Over the past month have you experienced any of the following? Please select those that apply to you.

No- Cannot get to sleep within 30 mins	**No**- Wake because of hunger	**No**- Wake due to pain
No- Wake up during the night	**No**- Feel too cold to sleep	**No**- Wake because of family members
No- Wake to use the bathroom	**No**- Feel too hot to sleep	**No**- Wake up tired
No- Cough or snore loudly	**No**- Have bad dreams	**No**- Feel sleepy during the day

Other:

Other Information

Is there any other information that you think we should know about?

Other information: