LESLIE ANDERS M.S., R.D., C.D.N.

Date____________

Name ____ Date of Birth ______________________

Address ___________________________________ City _____________ Zip Code ___________

E-mail __________________________________ Occupation _____________________________

Telephone No: Home ___________________________ Cell: _______________________________

Referred By ___________________________________

Medications (prescription and over the counter)

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____

Primary Care Physician ____________

PCP Phone Number ________________

Specialists (Other doctors)

____

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Supplements (Vitamins, minerals, herbs, other)

________________________ ________________________

________________________ ________________________

________________________ ________________________

What are your reasons and goals for seeking Nutritional Counseling?

1. _____________________ 3. _______________________

2. ______________________ 4. ______________________

Please list any symptoms that you have been experiencing

_________________________ _________________________

_________________________ _________________________

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Medical Conditions / Diagnoses

Please indicate the approximate year you were diagnosed with each condition

- ❑ High Blood Pressure/ Hypertension
- ❑ High Cholesterol/Triglycerides
- ❑ Diabetes
  - ❑ Retinopathy
  - ❑ Neuropathy
- ❑ Cardiovascular Disease
- ❑ Eating Disorders
- ❑ Reflux/GERD/Heartburn
- ❑ Inflammatory Bowel/Gut Disorder
  - ❑ Ulcerative Colitis
  - ❑ Crohn's Disease
  - ❑ Diverticulosis/Diverticulitis
- ❑ Stomach/Gastric disorders
- ❑ Irritable Bowel Syndrome
- ❑ Constipation
- ❑ Food Intolerances /Sensitivities
- ❑ Gluten intolerance
  - ❑ Celiac
- ❑ Liver Disease
- ❑ Renal/Kidney Disease
  - ❑ Kidney Stones
  - ❑ Gout
- ❑ Gallbladder Disease/ Gallstones

Other:

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Women's Health Conditions

- ❑ PCOS
- ❑ Menopause
- ❑ Menstrual history
- ❑ Pregnancy/Postpartum
- ❑ Other: ______________

- ❑ Allergies
- ❑ Respiratory Conditions
  - ❑ Asthma
- ❑ Cancer (Type) ________________
- ❑ Migraines/Headaches
- ❑ Arthritis
  - ❑ Osteoarthritis
  - ❑ Rheumatoid Arthritis

Auto-immune Diseases

- ❑ Lupus
- ❑ Multiple Sclerosis
- ❑ Sjögren's Syndrome
- ❑ Chronic Fatigue Syndrome
- ❑ Other: ________________

- ❑ Thyroid Condition
- ❑ Fibromyalgia
- ❑ Osteoporosis/Osteopenia
- ❑ Skin Conditions
  - ❑ Psoriasis
  - ❑ Eczema
  - ❑ Acne

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