ZEST Nutrition

New Client Form

Today's Date:

Name: _____ SSN: _____-_____-_____

DOB (MM/DD/YYYY): _____ Reason for Visit _____

Marital Status: Single__ Married__ Living with Partner__ Divorced__ Widowed__

Contact Information

Address: _____

City: _____ State: _____ Zip Code:_____

Phone Number: (_____)_____ Email: _____

Preferred method of contact: Phonecall Text Msg Email Mail

Emergency Contact Name: _____ Ph#: (_____)_____

How did you hear about us? _____

Personal Health History

Top Health/Nutrition Concerns: 1._____

2. _____

3. _____

Height: _____ Weight: _____

Recent Weight Loss / Gain? _____ If yes, how much?_____

Was the weight change intended? _____

Desired Weight: _____ Last age at desired weight: _____

Previous surgeries & years: _____

Current Medical Conditions: _____

Past Medical Conditions & Action Taken: _____

_____

_____

_____

_____

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Have you been diagnosed with…?:

☐ Type 1 Diabetes ☐ Type 2 Diabetes ☐ Pre-diabetes

☐ Cancer, type: _____

☐ Any heart condition or disease, type: _____

☐ High blood pressure ☐ High cholesterol

☐ Gastrointestinal (GI) issues, type: _____

☐ Vitamin/Mineral Deficiency, type: _____

☐ Food Allergies, type: _____

Current Medications/Supplements/Vitamins and Reason: _____

_____

Family History:

☐ Type 1 Diabetes, whom: _____

☐ Type 2 Diabetes, whom: _____

☐ Cancer, whom & type: _____

☐ Any heart condition, whom & type: _____

☐ High blood pressure, whom: _____

☐ High cholesterol, whom: _____

☐ Gastrointestinal (GI) issues, whom & type: _____

☐ Other, whom & what condition(s): _____

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Physical Activity:

What types of activity do you do?:

	Cardio			Strength Training			Other		
Type(s) (running, weight lifting, Zumba, climbing, etc.)	**1.**	**2.**	**3.**	**1.**	**2.**	**3.**	**1.**	**2.**	**3.**
Duration (minutes/day)									
Frequency (times/week)									

Tobacco Use:

Currently: ☐ Yes ☐ No Type: (cigarettes, chew, etc)_____

Amount per day: _____

Previous Use: ☐ Yes ☐ No Number of Years: _____

Alcohol Use:

Do you consume alcohol regularly now or have you ever in the past?

☐ No ☐ Yes: Currently ☐ 1-3 drinks/week ☐ 4-6 drinks/week ☐ 7-10 drinks/week ☐ 10+ drinks/week

☐ Yes: In the past ☐ 1-3 drinks/week ☐ 4-6 drinks/week ☐ 7-10 drinks/week ☐ 10+ drinks/week

Dietary:

Are you currently following a special diet? If so, what: _____

_____

How many meals do you eat per day? _____

About what time do you eat (if applicable): Breakfast_____ Lunch _____ Dinner _____

Snacks _____