Nutrition Assessment - Anthem Patients Only

Colorado Nutrition Counseling, LLC

Patient's Name _____ Date of Birth _____

Height _____ Weight _____ Age _____

Food Allergies? _____ Food Intolerance? _____

Medical History:
Check all that apply.

__ Diabetes* _____
__ High Cholesterol/Triglycerides
__ Irritable Bowel Syndrome
__ Celiac Disease
__ High Blood Pressure
__ Chronic Kidney Disease* Stage _____
__ Swallowing/Chewing Difficulties
__ Parkinson's Disease
__ Congestive Heart Failure
__ Previous/Current Eating Disorder
__ Kidney Stones
__ Chronic Constipation
__ Mental Illness* _____
__ Other* _____
_____
*Please specify

* Please bring a copy of your most recent lab results if available*

Have you been hospitalized in the last 3 months? Yes No

Do you exercise 30 minutes or longer at least 3 times per week? Yes No

Have you seen a registered dietitian before or received nutrition counseling in the past? Yes No
If Yes, where and when? _____

Emergency contact (Name and phone) _____
Can we release personal/medical information to this person if requested? Yes No
If no, is there someone else? _____

Have you tried any diets in the past? Yes No
If yes, which ones? _____
_____

* Please bring this form to your scheduled appointment*