REHABILITATION ASSOCIATES, INC.
MEDICAL DATABASE FOR MEDICAL NUTRITION THERAPY

Patient Name: _____ Today's Date:_____
Date of Birth: _____ Age: _____ Best Phone # to Reach You During Business Hrs. _____
Primary Doctor: _____ Primary M.D. Phone #_____
Referring Doctor: _____ Referring M.D. Phone #_____

Medical History: Please indicate whether you have been diagnosed with or treated for any of the following:

Overweight / Obesity
Underweight / Unintentional Weight Loss
Diabetes
Pre-Diabetes
Hypoglycemia
High Blood Pressure
Pre-Hypertension
High Blood Cholesterol
Congestive Heart Failure
Other Heart Problems _____
Stroke / Head Injury
Swallowing Issues

Cancer: Type? _____
Kidney Disease
Liver Disease
Lung / Breathing Problems
Osteoporosis / Osteopenia
Sleep Disorders
Anemia
Migraines / Headaches
Dizziness / Loss of Balance
Visual Problems
Gastrointestinal Problems
Thyroid Disorders

Eating Disorders
Food Allergies / Food Intolerances
Celiac Disease
Parkinson's Disease
Multiple Sclerosis
Seizures
Mobility Issues
Arthritis
MRSA or C. Difficile (C. Diff.)
Other Medical Condition(s):
_____
_____

☐ **I am seeking nutrition therapy for wellness, disease prevention and/or sport performance.**

Your primary reason for being here is: _____

How long have you had this problem? Days_____ Weeks_____ Months_____ Other:_____

Have you had this problem before? ☐Yes ☐No **If yes, how was it treated?** _____
_____

Have any relevant diagnostic tests been performed? X-Rays ____ MRI _____ Scans ____ Lab tests _____
Other: _____

THE SECTION BELOW FOR THERAPISTS ONLY: Please turn over and complete back side

Diagnosis: _____ Onset Date: _____

☐ **Patient is aware of diagnosis and prognosis as discussed with clinician.**

Surgery / Procedure: _____ (See above for date)

Additional History / Comments:

Please list any relevant injuries or surgeries and their dates: ☐ None ☐ See Below ☐ See Attached List
1)_____ Date:_____ 3)_____ Date:_____
2)_____ Date:_____ 4)_____ Date:_____

Is there any possibility you may be pregnant at this time? ☐Yes ☐No
Do you have a permanent disability rating? ☐Yes ☐No If yes, for what? _____

Medications: List all medications <u>and</u> supplements you take and the doctor (if any) who prescribed them:
Medications/Supplements: ☐ None ☐ See Below ☐ See Attached List

Medication/Supplement	Prescribing MD	Dosage	Frequency	Route
1.				
2.				
3.				
4.				
5.				

List <u>ALL</u> Allergies: _____

Health Habits and Lifestyle:

- Do you smoke? ☐Yes ☐No If yes, how much? _____
- Do you drink alcohol? ☐Yes ☐No If yes, how much? _____
- Height _____ Weight _____ Have you gained or lost weight in the past year? ☐Yes ☐No
  If so, how much? Gained_____ Lost_____
- Do you exercise at a gym, swimming pool, home or other facility? ☐Yes ☐No
- Do you have a history of anxiety or depression? ☐Yes ☐No
- Does emotional stress play a role in your current health status? ☐Yes ☐No

Social /Occupational: Please indicate all roles in which you participate:

☐Employee If checked, what is your occupation? _____
☐Parent ☐Caregiver ☐Student ☐Retiree ☐Other (Please specify): _____
Hobbies / Interests: _____
Is there any further information that would assist us in providing your care? _____

Date of next appointment with your referring physician: _____

I verify that the information provided above is accurate to the best of my knowledge.

Signed: _____ Name: _____
(Patient Signature) (Print Name)

To Be Completed by Clinician. Do Not Write Below this Line.

☐ Social and/or vocational screening completed.
- ☐ No additional referrals indicated.
- ☐ Needs identified during screening:_____
  (Services suggested)
- ☐ Patient has been informed of all available services at Rehabilitation Associates, Inc.

Reviewed by:_____
(Therapist Initials)

☐ **THIS DOCUMENT WAS REVIEWED BY: _____**

Medical Director