Rehabilitation Associates, Inc. Nutrition Medical Database

Date: _____ Patient Name: _____ Date of Birth: _____

Chosen Name (if different from legal name)/Nickname: _____

Legal Sex: _____ While we recognize a number of sexes/genders, unfortunately, many insurance companies and legal entities do not. Please understand that the legal name and sex listed on your insurance must be used on documents pertaining to insurance and billing. If your name used and/or pronouns are different from these, please let us know.

Pronouns (if comfortable sharing): _____

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

Dates of COVID Vaccine #1 _____ #2 _____

__ Overweight / Obesity	__ Liver Disease	___ Kidney Disease
__ Underweight/Unintended Weight Loss	__ Lung / Breathing Problems	___ Celiac Disease
__ Diabetes	__Sleep Disorders	___ Swallowing Problems
__ Pre-diabetes	__ Anemia	___ Crohn's Disease/Colitis
__ Hypoglycemia	__ Migraines / Headaches	___ Arthritis or Osteoporosis
__ High Blood Pressure or Pre-Hypertension		__ Cancer: Type:_____
__ High Blood Cholesterol	__ Eating Disorders	___ Mental illness
__ Congestive Heart Failure	__ Gastrointestinal Problems	___Other Medical Condition(s):
__ Stroke / Head Injury	__ Thyroid Disorders	_____
__ Food Allergies/Food Intolerances	__ **COVID-19**	_____

Your primary concern(s)/reason for being here is: _____

Please list any relevant medical testing: ☐ None ☐ See Below ☐ See Attached List

1)_____ Date: _____ 3)_____ Date:_____

2)_____ Date: _____ 4)_____ Date:_____

Medications & Nutritional Supplements: ☐None ☐See Attached List

Health Habits & Lifestyle:

Height _____ Weight _____ Have you gained or lost weight in the past year? ☐Yes ☐No

If so, how much? Gained_____ Lost_____ (Note time period lost or gained weight_____)

Do you smoke? ___ No ___ Yes - how much _____

Do you drink alcohol? ____ No ___ Yes - how much _____

Do you exercise? ☐Yes ☐No If so, explain? _____

Referring MD: _____ Date of next appointment with referring MD: _____

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

Patient name: _____ Patient Signature: _____

☐ **This document was reviewed by: _____(Medical Director)**