NEW CLIENT REGISTRATION

Client Information		Date:	
Name: M / F		DOB:	
Home Address:	City:	State:	Zip:
Cell Phone:	Home Phone:		
Email Address:			
Employer:	Work Phone:		

Primary Care Doctor

Name:	Phone #:
Address:	

Specialist (type):

Name:	Phone #:
Address:	

Specialist (type):

Name:	Phone #:
Address:	

Therapist (if applicable)

Name:	Phone #:
Address:	

Weight Information:

Height:	Weight:	Average weight last 2 years:	
Weight you would like to weigh:		Last age at that weight:	
Highest Adult Weight: Age:		Lowest Adult Weight: Age:	
Pre-Pregnancy Weight:		How much weight gain during pregnancy?	
Have you lost or gained weight recently?		How Much?	Time Frame?
How often do you weigh yourself?		Last complete physical exam?	

Check off how you currently feel about your body: ☐ Strongly Dislike ☐ Dislike ☐ Slightly Satisfied ☐ Satisfied ☐ Very Satisfied

Nutritional Concerns:

Reason For Consultation:

Referred By:

Nutritional Concerns	Current Conditions	Symptoms	Other Pertinent Conditions
☐ Anemia ☐ Celiac / Gluten Sensitivity ☐ Diabetes ☐ Digestive Problems ☐ Food Allergies ☐ Headaches / Migraines ☐ Heart Health ☐ High Blood Pressure ☐ High Cholesterol ☐ Hypo / Hyperglycemia ☐ Lactose Intolerant ☐ Low Energy ☐ Osteoporosis ☐ Thyroid ☐ Weight Loss ☐ Other _____ ☐ Other _____	☐ Cancer (type) _____ ☐ Celiac Disease ☐ Crohns Disease ☐ Diverticulitis / Diverticulosis ☐ Diabetes ☐ Food Allergies _____ ☐ Heart Disease ☐ High Blood Pressure ☐ High Cholesterol ☐ High Triglycerides ☐ Hypo / Hyperglycemia ☐ Hypo / Hyperthyroid ☐ Irritable Bowel Disease ☐ Osteoporosis ☐ Weight Gain ☐ Weight Loss ☐ Other _____ ☐ Other _____	☐ Anemic ☐ Bloating ☐ Constipation ☐ Decreased Appetite ☐ Depression ☐ Diarrhea ☐ Excessive Appetite ☐ Excessive Gas ☐ Headache / Migraine ☐ Low Energy / Fatigue ☐ Mood Swings ☐ Sensitive to Foods ☐ Shaky or Irritable if Hungry ☐ Weight Gain ☐ Weight Loss ☐ Other _____ ☐ Other _____	List all known food allergies, if Applicable and other conditions not listed on this form: _____ _____ _____ _____ _____ _____ _____

Nutritional / Dietary History

Medications currently taking (list names, conditions and dosages):

Supplements currently taking (list names and dosages):
Have you ever followed a special diet or taken any special diet products in the past? ☐ Yes ☐ No Please check off below if you have been on or tried any of the following weight-loss aids / plans: ☐ Appetite Suppressants ☐ Low Calorie ☐ Liquid Diet ☐ Lindora ☐ Carb / Fat Blockers ☐ Low Carb ☐ Vegetarian ☐ Weight Watchers ☐ Metabolic Enhancers ☐ Low Fat ☐ Jenny Craig ☐ Other _____

Nutrition Habits:

How many meals do you eat per day?	If you skip meals, what meal/s?
How many snacks do you eat per day?	What is a typical snack?
What time is your last meal or snack?	How many sodas/day? Per Week? ☐ Regular ☐ Diet
Do you have sugar cravings?	How many sweets/day? Per Week? Type?
How many ounces of water do you drink per day?	Number of caffeinated drinks per day? Type?
What other beverages do you drink? ☐ Milk ☐ Tea ☐ Juice ☐ Soda ☐ Lemonade ☐ Other Sweetened Drinks	
Do you tend to eat low fat or non-fat foods? ☐ Yes ☐ No	Do you avoid fats with your meals? ☐ Yes ☐ No
Do you eat processed foods regularly? ☐ Yes ☐ No	Do you eat fast food regularly? ☐ Yes ☐ No
How many meals per week do you eat fast food?	Do you out at a restaurant regularly? ☐ Yes ☐ No
How many meals per week do you eat at a restaurant?	Which restaurants?
Do you tend to rush when eating? ☐ Yes ☐ No	Do you eat due to emotions? ☐ Yes ☐ No
If yes, which emotions?	Do you feel out of control with certain foods? ☐ Yes ☐ No
If yes, which foods?	
Have you ever been diagnosed with an eating disorder? ☐ Yes ☐ No	
If yes, please describe any and all treatment:	
Name two healthy qualities about your present diet:	
List some dietary changes you would like to focus on:	

Social Information / Other:

Occupation:	Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed
Who prepares your meals?	Who does the shopping?
How many people in your family?	What stores do you shop at?
Age of children?	Hobbies?
Ability to sleep? ☐ No problem ☐ Needs Improvement ☐ Poor Number of hours sleep/night?	
Stress: ☐ Low ☐ Moderate ☐ High	Stress: ☐ Manage well ☐ Need help managing
Do you smoke? ☐ Yes ☐ No	If yes, how much?
Do you drink? ☐ Yes ☐ No	If yes, how much?
Do you exercise? ☐ Yes ☐ No	If yes, indicate type and frequency below:
Cardio:	
Resistance:	
Do you have any medical condition that would prevent you from exercising? ☐ Yes ☐ No	
If yes, name the condition:	

Our programs ARE NOT DIETS; they require a commitment to a lifestyle change. Because we only choose to work with committed clients, there is no refund if you are unable or unwilling to follow our recommendations. Pre-purchased sessions will expire 1 year from date of purchase. A 24-hour notice of cancellation is required to avoid being charged for the session.

WAIVER

I, the undersigned, have read, understand, and have answered the above health/medical survey questions fully and truthfully. I am aware of my responsibility to consult with my personal physician regarding my clearance to engage in any nutritional support program. I do hereby intend to be legally bound for myself and waive release of any and all rights and claims for damages I may have against Healthy Fit Nutrition, Inc. and Newport Nutrition and its dietitian administering this program, as well as the program creators themselves or anyone in connection with them, for any and all injuries suffered while following the nutritional program provided for me. I also understand and agree to the no refund policy stated above.

Client Signature: _____ Date: _____

Print Client Name: _____

Healthy Fit Nutrition, Inc. / Newport Nutrition
436 Heliotrope Avenue #2B, Corona del Mar, CA 92625 | 5181 Argosy Avenue, Huntington Beach, CA 92649
Phone: (949) 723-9533 • Fax: (714) 602-1636 • Email: healthyfit@earthlink.net • Web: www.healthyfitnutrition.net