Erin Naimi, RDN, CEDRD

Nutrition Therapist

(310) 551-0233

Name: _____ Date of Birth: _____ Age: _____

Referred By: _____

Mailing/Billing Address: _____

City: _____ State: _____ Zip Code: _____

Telephone (Home): _____ Telephone (Office): _____

Cell Phone: _____ Email address: _____

Occupation/Student: _____

Social Security Number: _____ Driver's License Number: _____

Emergency Contact: _____ Telephone #: _____

Relationship to Emergency Contact: _____

Primary Physician: _____ Telephone #: _____

Psychotherapist: _____ Telephone #: _____

Psychiatrist: _____ Telephone #: _____

Other: _____ Telephone #: _____

Other: _____ Telephone #: _____

Other: _____ Telephone #: _____

Abdominal Pain: Yes/No _____ How often? _____	Acid Reflux (GERD): Yes/No _____ How Often? _____	Sleep Issues: Yes/No _____
Diarrhea: Yes/No _____ How Often? _____	Elevated Blood Glucose: Yes/No _____ Date last checked: _____	Abnormal Hair Loss Yes/No _____
Constipation: Yes/No _____ How Often? _____	Elevated Blood Pressure: Yes/No _____ Date last checked: _____	Thyroid Issues: Yes/No _____
Nausea/ Vomiting: Yes/No _____ How Often? _____	Elevated Cholesterol: Yes/No _____ Date last checked: _____	Other lab work of significance: _____

Details related to above stated or any other medical concerns/ surgeries:

Family history of weight or medical concerns:

Medications (prescription):

Vitamin or Herbal supplements:

Food Allergies /Allergy Testing/ Reaction:

Caffeine Intake Per day: _____ **Type(s) of (Coffee, Soda, Tea, etc.):** _____

Alcohol intake Per day: _____ **Per week**: _____ **Cigarette Use:** _____

Water intake Per day: Low / Medium/ High _____ **# of cups or ounces / day:** _____

FEMALE CLIENTS: Age of onset of Menstruation: _____ **Do you currently menstruate:** Yes /No _____

IF NO, please explain:

Any issues/ concerns with your menstrual cycles?

Height : _____ **Current Weight *(This is optional*):** _____

Please share any information related to your weight, weight history, and your relationship to the scale that you think would be relevant to share.

Food Restrictions/ Fears:

History of Dieting or Eating Issues:

Exercise Frequency: _____

Type of Exercise/ Activity :

Do you Enjoy Movement and Exercise? What has your relationship with exercise been in the past and now?

Space for Any Additional Information You Would Like To Share: