

DIET THERAPY[©] PATIENT INTAKE FORM

Note: Only enter items that you are certain about

(* indicates required data)

*Patient Name: _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Email: _____ *Gender: M F *DOB: _____

(* indicates data required ONLY if doing calorie calculations)

#Height (barefoot): _____ #Weight (clothed): _____ #Wrist (circumference of dominant hand at wrist folds): _____

#Activity Level (check only one)

- Sedentary (little or no exercise, desk job or bed ridden)
- Light Activity (light exercise – sports 1 to 3 days per week)
- Moderate Activity (moderate exercise – sports 3 to 5 days per week)
- Very Active (hard exercise – sports 6 to 7 days per week)
- Extra Active (hard daily exercise – sports and physical job)

Surgery (very recent or pending – check only one)

- Minor
- Major

Infection (current only – check only one)

- Mild
- Moderate
- Severe

Lean Body Mass or Percent Body Fat (if known):

Trauma (very recent only)

If Pregnant - Trimester: 1 2 3

Muscular/Skeletal (sprains, fractures, etc.)

Food Allergies or Sensitivities

- | | | | | |
|--|---|---------------------------------------|--|---|
| <input type="checkbox"/> Bananas | <input type="checkbox"/> Gluten Foods (all) | <input type="checkbox"/> Soy | <input type="checkbox"/> Alcohol | <input type="checkbox"/> Synthetic foods |
| <input type="checkbox"/> Chocolate | <input type="checkbox"/> Gluten Foods (highest) | <input type="checkbox"/> Strawberries | <input type="checkbox"/> Caffeine | <input type="checkbox"/> Pesticide residues |
| <input type="checkbox"/> Citrus Fruits | <input type="checkbox"/> Peanuts | <input type="checkbox"/> Sulfites | <input type="checkbox"/> Carcinogens | <input type="checkbox"/> Refined sugars |
| <input type="checkbox"/> Corn | <input type="checkbox"/> Peppers | <input type="checkbox"/> Theobromine | <input type="checkbox"/> Fluoride/Chlorine | <input type="checkbox"/> All toxic foods |
| <input type="checkbox"/> Dairy | <input type="checkbox"/> Refined Sugars | <input type="checkbox"/> Tomatoes | <input type="checkbox"/> Foods children should avoid | |
| <input type="checkbox"/> Eggplant | <input type="checkbox"/> Shellfish | <input type="checkbox"/> Wheat | <input type="checkbox"/> Mercury contaminated foods | |
| <input type="checkbox"/> Eggs | | | | |

Other food allergies or sensitivities: _____

Vegetarian Intolerances:

- Red Meat
- Poultry
- Fish
- Dairy
- Eggs

Ethnic Options:

- Kosher foods only

Patient's Blood Type:

- O
- A (subtype unknown)
- A₁
- A₂
- B
- AB (subtype unknown)
- A₁B
- A₂B
- Rh negative

Primary diagnosis / chief complaint: _____

Other health factors to address: _____

Organs or Systems needing support (check any that apply)

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Adrenals | <input type="checkbox"/> Gall Bladder | <input type="checkbox"/> Lungs | <input type="checkbox"/> Prostate |
| <input type="checkbox"/> Bladder | <input type="checkbox"/> Gums/Teeth | <input type="checkbox"/> Lymphatic | <input type="checkbox"/> Skin |
| <input type="checkbox"/> Bones | <input type="checkbox"/> Hair/Scalp | <input type="checkbox"/> Male Reproductive Organs | <input type="checkbox"/> Spine |
| <input type="checkbox"/> Brain/Nerves (CNS) | <input type="checkbox"/> Heart | <input type="checkbox"/> Mammary Glands/Breasts | <input type="checkbox"/> Spleen |
| <input type="checkbox"/> Bronchi | <input type="checkbox"/> Intestines (GI tract) | <input type="checkbox"/> Muscles | <input type="checkbox"/> Thymus |
| <input type="checkbox"/> Ears (hearing) | <input type="checkbox"/> Joints | <input type="checkbox"/> Nails | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> Eyes (vision) | <input type="checkbox"/> Kidneys | <input type="checkbox"/> Pancreas | <input type="checkbox"/> Uterus |
| <input type="checkbox"/> Female Reproductive Organs | <input type="checkbox"/> Liver | <input type="checkbox"/> Pituitary Gland | <input type="checkbox"/> Veins/Arteries |