Initial Intake Form

Date ______________________

Name ____ Date of birth ______________________

Address ____

Best phone number to reach you ____

Highest weight/date _________/_________ Lowest weight /date _________/_________

Height _________________________ Current weight __________________________

Treatment team			
Name	**Type of treatment (psychotherapy, medication, behavior treatment)**	**Date of first consultation or treatment**	**How long did treatment continue? (if still being treated, please so state)**

Do you smoke?
☐ Yes ☐ No

Previous hospitalizations, serious illnesses or health problems	
Describe	**Date**

Have you been diagnosed with any of the following?		
☐ Acid Reflux	☐ Diabetes Type I	☐ PCOS
☐ Alcohol abuse	☐ Diabetes Type II	☐ Sleep Apnea
☐ Anemia	☐ Heart Disease	☐ Substance Abuse
☐ Arthritis	☐ High Blood Pressure	☐ Triglycerides
☐ Asthma	☐ High Cholesterol	☐ Ulcerative Colitis
☐ Cancer	☐ Hyperthyroidism	☐ Other:
☐ Celiac disease	☐ Hypothyroidism	☐ Other:
☐ Crohn’s disease	☐ Lactose Intolerance	☐ Other:
☐ Depression	☐ OCD	☐ Other:

Current Medications and Supplements			
Date started	**Medication**	**Dosage/frequency**	**Results: positive, neutral, negative**

Are you concerned about any of the following eating behaviors?		
☐ Anorexia	☐ Food restriction	☐ Overeating
☐ Binge Eating	☐ Laxative use	☐ Purging
☐ Bulimia	☐ Overexercise	☐

Have you ever had a fracture, stress fracture, or overuse injury?

Is there any family medical history that I should be aware of?

Caffeine, artificial sweetener, condiment use			
Do you use?	**What/which kind?**	**How much?**	**How often?**
☐ Alcohol			
☐ Artificial sweeteners			
☐ Caffeinated beverages			
☐ Cigarettes			
☐ Condiments			
☐ Drugs (other than medications)			
☐ Gum			
☐ Laxatives			

Menstrual history (if applicable)

Age at first period __________________ Are your periods regular? _______________________________

Date of last period __________________ Do your periods affect your mood or eating?_______________

If peri-menopausal, what age do you think you entered peri-menopause? _________________________

If post-menopausal, what age did you consider yourself post-menopausal _________________________

Describe your relationship with exercise: *Specifically what type of exercise and how often*

Describe any food restrictions *(allergies, intolerance, dislikes, religious reasons, vegetarian, etc.)*

How are you hoping I can help?

Theresa C Kinsella MS, RD, CDN
280 Madison Avenue, Suite 1004
New York, New York 10016
theresakinsellard@gmail.com
646.351.9148

©2014 Theresa Kinsella MS, RD