

METTLER CENTER NUTRITION & HEALTH HISTORY

Phone: (217) 356-6543
Fax: (217) 356-8010

A. Personal:

Last: _____ First: _____ M F Date of Birth: ____/____/____

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

Phone: (____) ____ - ____ Email: _____

Reason for choosing Mettler Center: _____

Primary health concern/goal: _____

B. Medical History:

Height: _____ Current Weight: _____ Realistic/Desired Weight: _____

1. Please indicate any recent weight changes:

Loss/gain	Duration of time

2. Please list latest lab results:

Lab	Result	Date	Lab	Result	Date
Total Cholesterol			Triglycerides		
LDL			Glucose		
HDL			Blood Pressure		

3. Please list any medications or dietary supplements you are taking:

Medication	For	Began Taking	Comments

4. Please identify any past or current medical conditions the dietitian should know about:

5. Please list any weight management programs participated in or nutrition counseling you have received:

6. Describe any barriers you have encountered when trying to lose/maintain/obtain weight:

C. Family History:

Describe the health history of your family members (include weight, heart disease, diabetes, high blood pressure, high cholesterol, etc.):

Mother	
Father	
Grandparents	

D. Exercise & Nutrition:

1. Do you exercise? yes no
If yes, ___ times/week for ___ years, or _____
2. Have you ever worked with a personal trainer? yes no
If so, provide details: _____
3. List any food allergies: _____
4. List any specific dietary patterns you follow (vegetarian vegan, etc.): _____

D. Social Habits:

1. How many people live in your household? Adults ___ Children ___
2. Who cooks in the home? _____
3. Where do you grocery shop? _____
4. How often do you eat out per week? Breakfast ___ Lunch ___ Dinner ___
5. How much alcohol do you consume per week? _____
6. How many soft drinks do you consume per week? Regular ___ Diet ___
7. What challenges do you foresee in accomplishing your health goals? _____

D. Meal Tracking:

Record a typical day of food intake. Include all food and beverages with specifics on type, size/amount, and brand.

Breakfast _____: _____	
Snack _____: _____	
Lunch _____: _____	
Snack _____: _____	
Dinner _____: _____	
Snack _____: _____	

After submitting this form you will be contacted by a Mettler Center representative who will schedule your appointment with a Registered Dietitian and take payment. No cancellations, only rescheduling accepted, which must occur within two weeks of original appointment.

Patient Signature: _____ Date: ____/____/____
(Signature of parent or guardian if under 18 years old)