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Healthy Weight Options, LLC

Patient Information Form for MNT, Mountainside PT

Today's date _____ Name _____

Phone _____ Email _____

Gender: _____ Height: _____ Weight: _____ Age: _____

What issues brought you to seek nutrition counseling? _____

What are your nutrition and health-related goals? _____

Do you have any of the following health conditions? (circle all that apply)

- | | | |
|------------------------------------|--------------------------|--------------------------------|
| Hypertension/high blood pressure | Diabetes | Prediabetes |
| Hypotension/low blood pressure | Arthritis | High Cholesterol |
| High Triglycerides | Constipation | Kidney Disease |
| Anorexia Nervosa or Bulimia | Celiac Disease | Gluten Sensitivity |
| Osteoporosis or Osteopenia | Liver Disease | Menopause |
| Hyperthyroidism | Hypothyroidism | Irritable Bowel Syndrome |
| Food Allergies (please list below) | Congestive Heart Failure | Autoimmune Disease (MS, LUPUS) |

Please list any other medical conditions and elaborate on any of the conditions circled above.

Please list all prescriptions, over-the-counter medications and herbal supplements you take on a regular basis.

Are you currently on a special diet? Yes/No If "yes," what kind? _____

At what activity level do you consider yourself? (circle one)

Sedentary Lightly Active Moderately Active Very Active Don't know

Do you engage in a structured exercise program? Yes/No If "yes," what and how often?

List of all people (with ages) living in your household, and note who does the cooking and grocery shopping _____

Please return this form to Mountainside Physical Therapy (12625 Lee Hwy, Suite A, Washington, VA 22747) or email to me at kay@healthyweightoptionsllc.com at least 24 hours before your appointment.