Nutrition Solutions

12911 120th Avenue NE • Suite B50 • Kirkland, WA 98034 • (425) 825-8088

Date: _____

Personal Information

Name: _____ Gender: Male Female

Date of birth: _____ Age: _____ Single / Married / Other

Address: _____

City: _____ State: _____ Zip: _____

Home phone: ( ) _____ Cell phone: ( ) _____

Work phone: ( ) _____ E-mail: _____

Preferred method of contact: _____ May I leave a message? _____

Employer: _____ Occupation: _____

How were you referred? _____

In order to bill your insurance, this information must be filled out for the PRIMARY insurance subscriber

(If the primary insurance subscriber is also the patient, you may skip this section)

Subscriber's name: _____ Subscriber's date of birth: _____

Subscriber's address: _____

Subscriber's employer: _____ Relationship to patient: _____

Health Information

Physician/Clinic: _____

Primary concern: _____

List any prescription medications you are taking and their purpose:

1. _____ 2. _____

3. _____ 4. _____

List any supplements (such as vitamins or herbs) and/or OTC medications you are taking:

1. _____ 2. _____

3. _____ 4. _____

List any known allergies to the following:

Drugs: _____

Foods: _____

Environmental (grasses, pollens, etc.): _____

Do you currently smoke or have a history of smoking? Yes No

If yes, please provide details: _____

Please identify if you or any family members have been affected by the following. Check the "Yes" box next to each condition that applies to you or one of your family members. Indicate the relationship or state self in the "Relation" column when applicable.

Condition	Yes	Relation	Comments
Anemia			
Cancer			
Depression			
Diabetes			
Eating disorders			
Heart disease			
High blood pressure			
High cholesterol			
Kidney disease			
Osteoporosis			
Stroke			
Other			

List any additional information you feel is important for dietitian to know:

_____

_____

_____