**Initial Patient Profile:  Personal Evaluation**

Patient Name_____          Date_____

What are your goals or expectations in working with me?

_____
_____
_____

List personal attributes or skills that you believe will help you meet your goals?

_____
_____
_____

What do you see as the most significant barriers to meeting your goals?

_____
_____
_____

What do you envision for yourself when you meet your goals?

_____
_____
_____

**MEDICAL HISTORY**

List any additional medical diagnosis or concerns besides the primary concern you listed on the patient profile:

_____

_____

_____

_____

List medications and/or supplements you are currently taking (or attach list)

_____          _____

_____          _____

_____          _____

_____          _____

Do you have any food or medication allergies or sensitivities?   ☐ Yes     ☐ No
If Yes, please list below:

_____          _____

_____          _____

Indicate if you there is family history of:

☐   Diabetes _____          ☐ Hypertension          ☐ Cancer _____

☐   Cardiovascular disease          ☐ Weight issues          ☐ Other_____

**LIFESTYLE FACTORS**

Do you sleep well?                   ☐ Yes ☐ No    _____

Do you have regular sleep habits? ☐ Yes ☐ No    _____

If yes, when do you typically get up?          _____

If yes, when do you typically go to bed?       _____

**Daily schedule:**

|  | Other | Activities | Food/Beverage Intake |
|---|---|---|---|
| 6 am | | | |
| 8 am | | | |
| 10 am | | | |
| 12 pm | | | |
| 2 pm | | | |
| 4 pm | | | |
| 6 pm | | | |
| 8 pm | | | |
| 10 pm | | | |
| 12 am | | | |
| 2 am | | | |
| 4 am | | | |

**Physical Activity**: Please list type of activity below

| Current | Past | Potential |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

**FOOD**

Who shops and cooks in the household? _____

How often are groceries purchased?    □ ___ x/ week   □ ___ x/ month

Where are groceries purchased?  (List all)

_____

How are meals prepared?

|  | □ Cook at home | □ Assembled | □ Take out | □ Eat out |
|---|---|---|---|---|
| Breakfast | ___ x/wk | ___ x/wk | ___ x/wk | ___ x/wk |
| Lunch | ___ x/wk | ___ x/wk | ___ x/wk | ___ x/wk |
| Dinner | ___ x/wk | ___ x/wk | ___ x/wk | ___ x/wk |

**FOOD PREFERENCES**

| FOOD TYPE | PREFERRED FOODS | DISLIKED FOODS | AVOIDED FOODS | TRIGGER FOODS |
|---|---|---|---|---|
| Protein |  |  |  |  |
| Dairy |  |  |  |  |
| Fruits and vegetables |  |  |  |  |
| Starches/ Sugars |  |  |  |  |
| Beverages |  |  |  |  |