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REGISTERED DIETITIAN  
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PT NAME: \_\_\_\_\_  
PROBLEM/DX: \_\_\_\_\_  
HT: \_\_\_\_\_  
WT: \_\_\_\_\_  
DATE: \_\_\_\_\_

**MEDICAL NUTRITION THERAPY- Initial Consultation**

Name:	
Date:	
Phone: (day)	
Phone: (cell)	
Email:	
Address:	
Age:	
Height:	
Weight:	
Medications:	
Supplements:	
Occupation:	

<b>Physician Name:</b>	
Address:	
Phone:	Fax:

<b>Therapist name:</b>
Address:
Phone:

**Reason for Consultation/Chief Complaint:**

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**Previous Eating Disorder Treatment: (Please include approximate dates)**

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**Living Situation:**

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What I hope to get out of Nutrition therapy:

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**Weight history: (within last 2 years)**

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Height: \_\_\_\_\_

Current weight/date: \_\_\_\_\_

Highest weight/date: -----

Lowest weight/date: \_\_\_\_\_

Weight losses/gains in past year (no. pounds time frame): \_\_\_\_\_

Usual weight: \_\_\_\_\_

What do you think you would weigh if recovered \_\_\_\_\_

Family weight history: (describe)

Mother:

Father:

Sister(s):

Brothers(s):

Who do you think you take after the most? \_\_\_\_\_

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**DiETING History: (List all diets you have been on with approximate dates, duration)**

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**Medical History: (Please place a check next to all that apply)**

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**I have recently been treated for the following: (Explain)**

Severe vomiting  
Severe diarrhea  
Dehydration  
Electrolyte disturbances  
Chest pain  
EKG abnormalities  
Low heart rate ( $\leq 60$ )  
Irregular heart rate  
Dizziness-lightheadedness  
Severe constipation  
Tooth problems  
Severe recent weight loss or gain  
Low weight  
Blood in vomit  
Esophageal problems  
Reflux  
Severe abdominal pain  
Lack of or loss of menstruation

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**Other:****I have a history of the following:**

I am a cigarette smoker (How much and how many?)  
I am either a male over 45 years or a female over 55 years old.  
I do not exercise much. (Describe)  
My doctor tells me I am overweight/underweight (Describe)  
I have high cholesterol (Describe)  
I have a family history of cardiovascular disease (Describe)  
I have a family history of diabetes (Describe)  
I have a history of high blood pressure (Describe)  
I have chest pain  
I have shortness of breath  
My heart has irregular beats  
I have a history of fainting/see spots/blacking out  
I get dizzy from sitting to standing position (Describe)  
I have a history of kidney or liver problems (Describe)  
I have swelling in my extremities (Describe)  
I struggle with dehydration  
I have hair loss/ breakage  
I have peach fuzz on my body  
I am intolerant to cold (Describe)  
I have documented osteopenia or osteoporosis  
I feel tired a lot  
I have a history of irregular labs  
I am often dehydrated  
I have sore/enlarged glands in my cheeks, neck or jawline  
I have lesions in my throat or esophagus  
I have nausea  
I have abdominal bloating (Describe)  
I am often constipated  
I have frequent diarrhea  
I have food allergies (Describe)  
I have dental problems that impair my ability to chew or swallow. (Describe)

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**Menstrual History:**

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Last menstrual period (duration): \_\_\_\_\_

Are you on birth control? Y \_\_\_\_\_ N \_\_\_\_\_ Describe: \_\_\_\_\_

Do you have a history of amenorrhea? Y \_\_\_\_\_ N \_\_\_\_\_ Describe: \_\_\_\_\_

Approximate weight where period stopped: \_\_\_\_\_ Describe: \_\_\_\_\_

Have you ever had a bone density study? \_\_\_\_\_

Do you take supplemental calcium or Vit D? \_\_\_\_\_

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**Eating History:**

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I go off and on diets

I am unable to eat socially

I struggle with grocery shopping

I am afraid to eat certain foods

I restrict food

I skip meals

I do not eat between meal snacks

I restrict fluids

I water load instead of eat

I have eating rituals

I have "tricks" to suppress my appetite

I take diet pills

I take diuretics

I use laxatives

I use Ipecac

I use drugs

I drink alcohol

I use enemas

I abuse caffeine I weight myself a lot

I am generally dissatisfied with my weight.

I body check

I compare my weight to others

I ignore my hunger cues

I have episodes where I overeat

I binge eat (feel out of control)

I eat compulsively

I binge and purge

I binge eat but do not purge

I vomit after small or normal amts of food

I purge only after I binge

I restrict during the day and binge at night

I chew and spit food out

I eat in a hurry

I eat standing up

I eat in my car

I eat while watching t.v.

I eat according to the clock

I feel the need to finish it all "clean plate club "

I eat to reward self

I eat to punish myself

I stop eating before I feel satisfied

I eat until I feel sick

I do not know when I am hungry

I do not have a sense of fullness

I do not know when I am satisfied

**TYPICAL DAY OF EATING:**

please be specific with portion sizes, include fluids consumed with each meal and snack  
please circle if meal was a binge and place a "p" next to any foods purged

**Wake: (time)** \_\_\_\_\_

Breakfast: (time) \_\_\_\_\_

Snack: (time) \_\_\_\_\_

Lunch: (time) \_\_\_\_\_

Snack: (time) \_\_\_\_\_

Dinner: (time) \_\_\_\_\_

Snack (time) \_\_\_\_\_

**Bed: (time\_\_\_\_\_)**

Are weekend patterns the same? If no, explain:

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My primary binge foods are:

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My primary eating rituals are:

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My primary protein sources are:

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My primary vegetable sources are:

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My primary fruit sources are:

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My primary dairy sources are:

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My primary carbohydrate sources are:

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My primary fat sources are:

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Name your primary fiber sources

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Name your primary sources of sweets:

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Name your primary restaurant choices: (Include coffee shops, fast food)

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**Exercise History:**

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I have to exercise everyday  
I exercise to compensate for what I ate

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Exercise Routine: (type of exercise, frequency, duration)

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