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Pre-Consult Questionnaire

Name: _____ DOB: _____ Sex M / F

Phone: _____ Email: _____

Address: _____

1. Please list any previous medical diagnoses, conditions, and eating related challenges.

2. Please list any allergies/sensitivities to foods, vitamins, or medication.

3. Please list any medications you are currently taking.

4. Please list any supplements you are currently taking.

5. Please list your most pressing health concerns & symptoms - conditions, aches & pains, gut symptoms – in order of importance. (A - being the most pressing)

A.
B.
C.
D.
E.

6. Please list any health goals/nutrition support you would like to achieve i.e. Symptom relief, tips for healthy snacks, cooking recipes, reading food labels, restaurant menu ideas.

7. Please list any labs tests done within the last 12 months and/or any specialty labs.

How did you hear about us? _____

Questionnaire Date: _____