Eating Healthy 4 Life
Elizabeth Pecoraro, MS, RD, CDN
100 S. Bedford Rd, Mount Kisco, NY 10549
elizanne1@gmail.com
914.393.4116

Personal Information

Name: _____

Date: _____

Email: _____

Address: _____

_____

Phone: _____

Date of birth: _____ Sex: _____

Height: _____Present weight: _____

Referred by: _____

Medical History: Please circle all that apply.

Diabetic: Type 1 or Type 2

Glucose Intolerance

High blood pressure

High cholesterol

Obesity/Overweight

Gastrointestinal conditions (please specify):_____

Thyroid disease

Eating disorder (please specify): _____

Additional diagnoses not listed:

_____

_____

Medications/supplements you are currently taking:

_____

_____

Do you smoke? _____

Do you drink alcoholic beverages? _____

If so, what type and how often? _____

Any food allergies? _____

How many hours do you sleep?_____

Weight History

Have you had any recent weight gain or weight loss in the last year? _____

If yes, how much? _____

What is your goal weight? _____

Have you been on any diets in the past? _____

If yes, which ones and were they successful? _____

Do you participate in a regular exercise program? _____

If so, how many times per week and what is the activity? _____

_____

Meal Preparation

Are the majority of your meals prepared at home? _____

If so, who prepares them? _____

Who goes grocery shopping? _____

Do you frequently eat out? _____

If so, what types of restaurants do you go to? _____

How many people live in your household and ages? _____