

**First Health Associates, SC – Nutritional Therapy New Patient Form**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

What is the main reason for your visit with the Nutritionist? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you received any treatment for this condition by another Health Professional?     Y     N  
If Yes, Who? \_\_\_\_\_

What form(s) of treatment have tried?  
\_\_\_\_\_  
\_\_\_\_\_

How Long? \_\_\_\_\_

Have you ever worked with a Nutritionist or Registered Dietitian?     Y     N  
Explain: \_\_\_\_\_

Is there anything else you would like the Nutritionist to know?  
\_\_\_\_\_  
\_\_\_\_\_

Patients Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Nutritionist Reviewed: \_\_\_\_\_ Date: \_\_\_\_\_