Lynn Victory, MA, RD, LD
Cynthia Thomas, RD, LD, CDE
710 Pettigru Street
Greenville, SC 29601
(864) 271-1199

PLEASE COMPLETE THIS QUESTIONAIRE & BRING TO YOUR FIRST APPOINTMENT.

Today's Date Your Full Name

DOB Age Email

Address City/State/Zip

Phone (Home) (Work) (Cell)

Emergency Contact Relationship Phone

Referral Source

Physician Phone

Therapist (if applicable) Phone

Psychiatrist (if applicable) Phone

Other:

I give Lynn Victory or Cynthia Thomas permission to contact the above if necessary to discuss my therapy.

Signiture Date

MEDICAL HISTORY

Describe any serious or longstanding illness you have had in your life.

____

____

____

List any surgeries and their approximate dates.

____

____

____

LIST ANY MEDICATIONS YOU ARE TAKING **AT THIS TIME**		
NAME OF MEDICATION	DOSAGE	HOW OFTEN TAKEN

List any medications that have caused you to experience severe side effects (but not allergic reactions):

EDUCATION & EMPLOYMENT

Education

☐ Did not complete High School ☐ Completed High School ☐ Completed business/ technical training ☐ Completed College ☐ Completed Graduate

Occupation: ____

What do you do for fun/recreation? (include hobbies, social activities, clubs, special interest groups, etc)

____

What are your strengths? (include skills and talents that it takes to be good at the activity/hobby and other qualities you may possess such as patience, quick thinking, persistence, attention to detail, etc.)

____

What areas of your life are most satisfying to you (career, parenting, friendships, etc.)

____

GOALS AND EXPECTATIONS

Describe your goal(s) for nutrition therapy

____

____

____

____

During the coming weeks, what support systems will be available to help you deal with these problems:

☐ Friends ☐ Spouse/Relatives ☐ Neighbors ☐ Church ☐ Specify other: