Initial LEAP Patient Consult Form – Return to:

Last Name	First Name	Referring Physician/Dietitian Courtney Rinehold RDN, CDN, CLT
Phone	Alt. Phone	Gender Male ☐ Female ☐ Date of Birth

Street Address	City	State	Zip	Email Address

Health History

Chief Complaints & Diagnoses (Duration in parentheses)

Treatment History (What have you tried?):

Ever tested for Celiac Disease/When/Results?

What Medications are you currently taking for this or any other condition? (OTC & Rx – specify which meds for which condition):

Does anyone in your family, including you have allergies of any kind (in other words, cat, dust, pollen, food, meds, etc.)?	Are there any known foods that "don't agree" with you?

Do you experience, on a frequent basis any of the conditions/symptoms listed below
Using the following remarks: **D**=Daily, **W**=Weekly, **O**=Occasionally, **S**=Severe, **M**=Moderate/not severe

	Fatigued		Migraine		Heartburn/Reflux
	Restless/Hyperactive		Stuffy nose		Diarrhea/Loose stools
	Sleepy during day – Insomnia at night		Throat clearing		Constipation
	General Malaise (feel lousy)		Dark circles/puffy eyes		Bloating, distention, gas
	Depressed/Mood swings/Irritability		Muscle or joint pain		Abdominal pain
	Headaches other than Migraine		Water retention/weight fluctuations (shoes, jewelry, watches, clothes fit tighter or looser on a day-to-day or weekly basis)		

Eating Habits/Lifestyle Considerations

What is your occupation?	How often do you cook from scratch?	How often do you eat out?

Do you tend to skip meals?	Do you ever eat for comfort?	What situation(s) cause you to eat for comfort?

What areas of your life do your health problems interfere with?	What foods (if any) do you crave?	Is there any food you could not give up for 2 weeks?

On a scale from 1-10, how badly are these problems affecting your life?	On a scale from 1-10, how committed are you to getting better?

Notes/Recommended Therapy Options

Anything else you'd like to share:

Return to RD Fax: 260-818-2121 or email to: courtneyRD83@gmail.com

Initial Symptom Survey

Date:	Patient Name:	Practitioner: Courtney Rinehold RDN, CLT

INSTRUCTIONS: Score every symptom based on your experience **OVER THE PAST MONTH**. Using the SCALE OF SYMPTOM POINTS listed below, FILL IN the appropriate score to the left of EVERY symptom listed. Write the "Grand Total" at the top. Also note the number of missed work days you have had in the last month due to illness.

SCALE OF SYMPTOM POINTS
IF you did not suffer from the symptom ever or almost never, leave it blank.
1 = **OCCASIONALLY** (less than 2 times per week) and symptom **was MILD**
2 = **FREQUENTLY** (2 or more times per week) and symptom **was MILD**
3 = **OCCASIONALLY** (less than 2 times per week) and symptom **was SEVERE**
4 = **FREQUENTLY** (2 or more times per week) and symptom **was SEVERE**

Grand Total:	**# Missed Work Days**

CONSTITUTIONAL		**NASAL/SINUS**		**MUSCULOSKELETAL**	
	Fatigue (sluggish, tired)		Post nasal drip		Joint pains
	Hyperactive (nervous energy)		Sinus pain		Stiff joints
	Restless (can't relax/sit still)		Runny nose		Muscle aches
	Daytime sleepiness		Stuffy nose		Stiff muscles
	Insomnia at night		Sneezing		Tics (facial or otherwise)
	Malaise (feeling lousy)		TOTAL (0-20)		Muscle spasms
	Seizures	**MOUTH/THROAT**			Muscle cramps
	TOTAL (0-28)		Sore throat		TOTAL (0-28)
EMOTIONAL/MENTAL			Swollen throat	**CARDIOVASCULAR**	
	Depression		Swelling/burning lips/tongue		Irregular heartbeat
	Anxiety (fears, uneasiness)		Gagging/throat clearing		High blood pressure
	Mood swings (rapid changes)		Canker sores		TOTAL (0-8)
	Irritability		Difficulty swallowing	**DIGESTIVE**	
	Forgetfulness		TOTAL (0-24)		Heartburn/reflux
	Lack of concentration/Brain fog	**LUNGS**			Stomach pains/cramps
	Low sex drive		Wheezing		Intestinal pains/cramps
	TOTAL (0-28)		Chest congestion		Constipation
HEAD/EARS			Dry cough		Diarrhea
	Headache (not migraine)		Wet cough		Bloating sensation
	Migraine		Shortness of breath		Gas (of any kind)
	Earache		TOTAL (0-20)		Nausea
	Ear infection	**EYES**			Vomiting
	Ringing in ears		Red or swollen eyes		Painful elimination
	Itchy ears		Watery eyes		TOTAL (0-40)
	Discharge from ears/ Fluid in ears		Itchy eyes	**WEIGHT MANAGEMENT**	
	Sensitivity to sound		Dark circles or "bags"	Current weight:	
	TOTAL (0-32)		Sensitivity to light		Fluctuating weight
SKIN			Aura		Food cravings
	Blemishes, acne		TOTAL (0-24)		Water retention
	Rashes or hives	**GENITOURINARY**			Binge eating or drinking
	Eczema or psoriasis		Increased urinary frequency		Purging (all methods)
	"Rosy" cheeks		Painful urination		TOTAL (0-20)
	Flushing		Bladder pain	**LIST OTHER SYMPTOMS:**	
	Itchy skin		Bedwetting		
	TOTAL (0-24)		TOTAL (0-16)		