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 (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: