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NUTRITION AND HEALTH HISTORY

Please complete the questions on all pages. If you are not sure of the answer, leave it blank. (All information is treated as confidential)

Name:…………………….. …………………………….. (Date)…………………………(Birth Date……)…… ……….

Address:…….

City:……………………………… State:……Zip Code:………………Email:…………………………………………….

Tel.: (Bus)………………………………… (Res)……………………………………(Fax)………………………………….

Referred by ………………………………………………………………………………………………………..

Reason for referral?……………………………………………………………………………………………….

Physician: ……………………………………………………………. …Tel:……………………………………………..

Address: ………………………………………………………………. ………………………………………………….

May he or she be notified of your treatment? ………………………………………………………………………

Credit Card #:… ………………………………………………………… Expiration Date:…………………………….

Insurance:…….

Plan and I.D.#:…………………………………………………………………………………………………….

Marital status:…………………………How many children do you have? ……………………………………………….

Occupation: ……………………………………………………………………… Work hours:……………………………..

Travel time to work?………………………………………Do you like your job?…………………………………………….

HEALTH HISTORY

Describe your medical history: ………………………………………………………………………………………..

……….

Are you taking any medications? Please list:………………………………………………………………………….

……….

Describe your family health history: ………………………………………………………………………………………..

………..

Have you ever been advised by your physician to follow any type of diet? (low-cholesterol, low-sodium, low-carbohydrate/sugar, etc.)………………………………………………………………………………………………

What changes did you make at the time?……………………………………………………………………………….

Do you suffer from constipation?……………………………………………………………………………………….

Do you smoke?…………………………………….If yes, how many per day?……………………………………………..

How much alcohol do you drink?………………………………………………………………………………………..

Do you participate in regular physical activity?…………………Do you enjoy it?……………………………………..

What type?………………………………………. ……………How often?…………………………………………………

When do you go to bed?…………………………………When do you wake up?………………………………………

How is your energy level?………………………………….How is your stress level?…………………………………..

How do you deal with your stress?……………………………………………………………………………………..

Rank the following items in order of importance with 1 being most important and 7 being least important:

Job…….Relationships…….Food……Health……..Exercise…….Free Time………Spirituality…….

NUTRITION HISTORY

Height:…………………… Weight:…………………….. Desired weight:…………………… IBW:……………………

Wrist:…………………… BMI:………………………… Age:…………………… …….Sex:………………………..
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What is the most you have weighed as an adult?……………………………………………………………………….

What is the least you have weighed as an adult?……………………………………………………………………….

Have you ever tried to lose weight before?……………………………………………………………………………

Type Diet:………………………..Weight lost:…………………………How long did you keep it off ?………………..

Type Diet:………………………..Weight lost:……………………….How long did you keep it off?…………………

Type Diet:………………………. Weight lost:………………………How long did you keep it off?…………………..

Have you ever used laxatives for weight loss?……………………………………………………………………………..

Have you ever vomited for weight control?…………………………………………………………………………………

Have you ever used excessive exercise for weight control?………………………………………………………………….

Are your menstrual periods regular?……………………………………………………………………………………..

Are you taking any vitamin/food/herb supplements?…………………………………………………………………………….

……….

Are you allergic to any foods?…………………………………………………………………………………………

Do you avoid any foods for religious/ethical/cultural reasons?……………………………………………………………….

………..

How many cups of coffee do you drink per day?………………………………………………..…………………………..

How much milk do you drink per day?……………………………………………………………………………………….

How many glasses of water do you drink per day?…………………………………………………………………………

What are your favorite foods?……………………………………………………………………..…………………………..

What foods do you particularly dislike?…………………………………………………………………………………..

Do you like: Yogurt:……………. Cheese…………… Fruit……………….. Cereals…………………

Vegetables………. Salads…………. Eggs………………… Breads…………………

Meats:……………. Poultry:…………. Fish/seafood:………… Pasta/Rice…………

What vegetables do you eat regularly?…………………………………………………………………………………

What fruits do you eat regularly?……………………………………………………………………………………………

Do you eat when you are:

Tired	*Y/N*	*Bored*	*Y/N*	*Happy*	*Y/N*
Depressed	*Y/N*	*Stressed*	*Y/N*	*Frustrated*	*Y/N*

The following are questions about your typical eating pattern:

How many days per week do you eat (Breakfast)………………(Lunch)…………….(Dinner)…………….

How often do you snack? ( ) Once daily ( ) Twice daily ( ) Three times daily

When do you usually snack?……………………………………………………………………………………….

What do you usually eat for snacks?……………………………………………………………………………….

Do you eat out?………………………………………………… How often?……………………………………………….

Which restaurant (s) do you usually choose?……………………………………………………………………….

……….

……….

Do you eat standing up?……………………………… Do you eat at the table?………………………………………

Do you set the table?…………………………Do you feel you eat fast?…………………………………………………….

Do you engage in other activities when you eat?…………………………………………………………………….

Who usually prepares the food at home?………………………………………………………Do you cook?……………

Do you have a stove?…………Refrigerator/Freezer?…………Oven?…………Sink?…………Microwave:…………

Who usually does the grocery shopping?…………………………………………………………………………………

Do you read the labels?……………………. .What do you look for on the labels?……………………………………..

……….

Is there any member of your household on a special diet?…………………………………………………………….

List family members, ages, weight status and medical history:……………………………………………………

……….

……….

……….

Would you like to change your eating habits? ( ) Yes ( ) No

If yes, please explain why?…………………………………………………………………………………………….

……….

To the best of my knowledge the above information is correct:

Date:………………………………… *Signature:…………………………………………………………………*