Patient Nutrition History

Complete this form and bring it to your Registered Dietitian appointment.

GENERAL INFORMATION:

Last Name:_____ First Name:_____
Street Address:_____
City: _____ Zip Code: _____ Phone Number: _____
Email Address: _____ Gender: □ Male □ Female
Date of Birth:____/____/____ (mm/dd/year) Age: _____

Do you give the nutritionist consent to contact you via email regarding your diet?
□ Yes □ No

Do you give the nutritionist consent to contact you via phone regarding your diet?
□ Yes □ No

Who referred you to nutrition counseling? _____

What are your main reasons for seeking nutrition counseling?
_____
_____
_____

List any medications, vitamins, and/or supplements you are currently taking:
_____ _____ _____
_____ _____ _____
_____ _____ _____

List all current and past medical conditions:
_____
_____
_____

WEIGHT HISTORY:

Highest Adult Weight: _____ Lowest Adult Weight:_____
What is your Goal Weight? _____
Are you concerned with your weight? □ Yes □ No
In the past 6 months, have you recently □ lost weight □ gained weight □ stayed the same?
Do you weigh yourself? □ Yes □ No
If yes, how often? _____ What kind of scale do you use? _____

STAFF ONLY

Date:__/__/__
Height:_____ Weight:_____ BP:_____ Pulse:_____
Notes:_____
_____
_____

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Have you ever used or engaged in the following for weight loss? Check all the apply:

- ☐ Over the Counter Diet Pills
- ☐ Laxatives
- ☐ Fad Diets
- ☐ Vomiting
- ☐ Excessive Exercising
- ☐ Liquid Diets
- ☐ Diuretics
- ☐ Prescription Appetite Suppresants
- ☐ Other:_____ _____

DIET HISTORY:

List any food allergies, intolerances or dislikes (foods you do not eat):

_____

_____

Are you currently following any special diets?

_____

_____

List what you eat in a typical day for each meal:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

On average, how many ***servings per day*** do you consume of the following:

_____ Fruits
_____ Vegetables
_____ Dairy (yogurt or milk)
_____ Starches (bread, potatoes, rice, pasta)
_____ Beans/Legumes
_____ Chicken
_____ Fish
_____ Turkey
_____ Tofu
_____ Pork, Ham, Bacon
_____ Beef
_____ Salty snacks (chips, crackers, popcorn)
_____ Sweets/desserts (candy bars, cakes, cookies, ice cream)

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On average, how many ***servings per day*** do you consume of the following beverages:
(1 cup = 1 serving)

_____ Caffeinated Coffee
_____ Caffeinated Tea
_____ Regular soda (coke, sprite, pepsi, etc)
_____ Diet soda
_____ Sports drinks
_____ Water
_____ Sweet drinks (lemonade, sweet tea, etc)
_____ Energy drinks (red bull, monster, 5 hour energy)
_____ Fruit juice (apple, orange, grape, etc)

How many alcoholic drinks (beer, wine, liquor) do you have ***per week***? _____

How many times ***per week*** do you go out to eat? _____ What do you order when you eat out?_____

How many times ***per week*** do you cook at home? _____

Where do you go grocery shopping? _____

What are your obstacles for improving your health? Check all that apply.

- ☐ Emotional or mental stress
- ☐ Inactive at workplace
- ☐ Lots of food at work
- ☐ Finding time to prepare or eat nutritious food
- ☐ An active social life
- ☐ Frequent travel
- ☐ Lack of support
- ☐ Health problems
- ☐ Emotional Eating – eating due to stress, boredom, anxiety, sadness, etc.
- ☐ Eating out
- ☐ Lack of energy/tired
- ☐ Work commitments
- ☐ Family and/or personal commitments
- ☐ Inactive social life
- ☐ Other:_____

EXERCISE:

Are you currently exercising? ☐ Yes ☐ No

If yes, list the type, duration, and frequency of exercise:

_____

_____

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If you are currently **NOT** exercising, which of the following would you most likely try?

- ☐ Running/jogging
- ☐ Walking
- ☐ Swimming
- ☐ Aerobics class
- ☐ Yoga/Pilates
- ☐ Spinning classes
- ☐ Zumba
- ☐ Weight lifting
- ☐ Home exercise videos
- ☐ Other (Please indicate):_____ _____

List any medical limitations that would interfere with your ability to exercise:

SLEEP/STRESS:

Indicate if you have difficulty with the following: *Check all that apply.*

- ☐ Falling asleep
- ☐ Staying asleep
- ☐ Waking up in the middle of the night
- ☐ Other: _____

On average, how many hours of sleep do you get each night? _____

How many hours do you require each night in order to feel rested? _____

Rate your current stress level on a scale of 0-10, with 0 being no stress and 10 being the most stressed: _____

Provide any additional information you feel might be helpful to the dietitian:

_____

_____

_____

_____