NUTRITION INTAKE PAPERWORK

GENERAL PATIENT INFORMATION

PATIENT NAME: _____ DATE OF BIRTH:_____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

PHONE NUMBER: _____ EMAIL: _____

NUTRITION HISTORY

Have you ever had a nutrition consultation? ..... o YES o NO

Have you made any changes in your eating habits because of your health? ..... o YES o NO

If Yes, please describe: _____

_____

Do you currently follow a special diet or nutritional program? ..... o YES o NO

If Yes, please check all that apply

o Low Fat	o Low Carbohydrate	o High Protein	o Low Sodium
o Diabetic	o No Dairy	o No Wheat	o Gluten Restricted
o Vegetarian	o Vegan	o Specific Program: _____	

BODY MEASUREMENTS

Current Height: _____

Current Weight: _____

Usual Weight Range (+/- 5 lbs.): _____-_____

Desired Weight Range (+/- 5 lbs.): _____-_____

Highest Adult Weight: _____

Lowest Adult Weight: _____

Do you experience weight fluctuations greater than 10 pounds? o YES o NO

How often do you weigh yourself? o Daily o Weekly o Monthly o I do not normally weigh myself

Have you ever had your metabolism (resting metabolic rate) checked? ..... o YES o NO

If Yes, what was your result? _____

EATING BEHAVIORS

Do you avoid any foods in particular? ..... o YES o NO

If Yes, please describe the type of food and the reason: _____

_____

If you could only eat a few foods a week, what would they be? _____

_____

_____

_____

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Do you do the grocery shopping? ..... o YES o NO

If No, who does the shopping? _____

Do you read food labels? ..... o YES o NO

Do you cook? ..... o YES o NO

If No, who does the cooking? _____

How many meals do you eat out per week? _____

Please check all factors that apply to your current lifestyle and eating habits:

o Fast Eater	o Erratic Eating Pattern	o Eating Too Much
o Late Night Eating	o Dislike Healthy Foods	o Time Constraints
o Eat More than 50% of Meals Away from Home	o Travel Frequently	o Non-Availability of Health Foods
o Do Not Plan Meals or Menus	o Reliance on Convenience Items	o Poor Snack Choices
o Significant Other/Family Members Do Not Like Healthy Foods	o Significant Other/Family Members have Special Dietary Needs or Food Preferences	o Love to Eat
o Eat because "I Have To"	o Have a Negative Relationship with Food	o Struggle with Eating Issues
o Emotional Eater (Tendency to eat when sad, lonely, depressed, bored)	o Eat Too Much under Stress	o Eat Too Little under Stress
o Do Not Care to Cook	o Eating in the Middle of the Night	o Confused about Nutrition Advice
o History of Disordered Eating		

The MOST IMPORTANT thing I should change about my diet to improve my health is: _____
_____
_____
_____

SMOKING

Do you currently smoke? ..... o YES o NO

If Yes, for how many years? _____

How many packs do you smoke per day? _____

Have you attempted to quit smoking? ..... o YES o NO

How many times have you attempted to quit smoking? _____

Have you been exposed to secondhand smoke? ..... o YES o NO

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ALCOHOL INTAKE

How many drinks do you consume per week? *(1 drink = 5oz. wine, 12oz. beer, 1.5oz. spirits)*

o None o 1 – 3 o 4 – 6 o 7 – 10 o More than 10

OTHER SUBSTANCES

Do you consume caffeine?..... o YES o NO

How many cups of coffee do you consume per day?

o None o 1 o 2 – 4 o More than 4

How many cups of tea do you consume per day?

o None o 1 o 2 – 4 o More than 4

How many cups of caffeinated soda or caffeinated diet soda do you consume per day?

o None o 1 o 2 – 4 o More than 4

What is your favorite type of soda? _____

Have you ever used IV or inhaled recreational drugs? ..... o YES o NO

EXERCISE

Please list your Current Exercise Program (including activity, number of sessions per week, and duration of activity)

Activity	Type of Activity	Frequency per Week	Duration (minutes)
Stretching			
Aerobic Exercise			
Strength Training			
Other *(yoga, pilates, crossfit, etc)*			
Sports & Leisure *(golf, tennis, rollerblading)*			

Rate your level of motivation for including exercise in your life..... o LOW o MEDIUM o HIGH

Please list any problems that limit physical activity: _____

_____

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SLEEP/REST

On average, how many hours do you sleep each night?..... o > 10 o 8 – 10 o 6 – 8 o < 6

Do you have trouble falling asleep? ..... o YES o NO

Do you feel rested upon awakening? ..... o YES o NO

Do you have problems with insomnia? ..... o YES o NO

Do you snore? ..... o YES o NO

Do you use any sleeping aids? ..... o YES o NO

READINESS ASSESSMENT

Rate on a scale of 5 (Very Willing) to 1 (Not Willing)

In order to improve your health, how willing are you to:

Significantly modify your diet ..... o 5 o 4 o 3 o 2 o 1

Take several nutritional supplements each day ..... o 5 o 4 o 3 o 2 o 1

Keep a record of everything you eat for the day ..... o 5 o 4 o 3 o 2 o 1

Modify your lifestyle (work demands, sleeps habits, etc.) ..... o 5 o 4 o 3 o 2 o 1

Practice relaxation techniques ..... o 5 o 4 o 3 o 2 o 1

Engage in regular exercise ..... o 5 o 4 o 3 o 2 o 1

Have periodic lab tests to assess your progress ..... o 5 o 4 o 3 o 2 o 1

Rate on a scale of 5 (Very Confident) to 1 (Not Confident at All)

How confident are you in your ability to organize and follow through on the above health related activities? o 5 o 4 o 3 o 2 o 1

If you are not confident in your ability, what aspects of yourself or your life lead you to question your capacity to fully engage in the above activities? _____

_____

_____

Rate on a scale of 5 (Very Supportive) to 1 (Very Unsupportive)

At the present time, how supportive do you think the people in your household will be to your implementing the above changes? o 5 o 4 o 3 o 2 o 1

Comments: _____

_____

_____

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MEDICATIONS

Please provide the names of medications, supplements, and/or antibiotics that you are currently taking. If you already have a premade list, please feel free to attach to your paperwork.

Medication/Supplement	Dosage	Frequency

ALLERGIES

Please list any known allergies:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

WOMEN'S REPRODUCTIVE HEALTH

Please indicate the date of your last menstrual cycle: _____

Menstrual Cycle Patterns – *Please check all that apply*

o Regular Periods o Irregular Periods

o Heavy Periods o Light Periods

o No Periods

Are you currently taking prescription contraceptives? ..... o YES o NO

If Yes, please indicate the type of contraceptive: _____

REVIEW OF SYSTEMS

Please indicate if you are currently experiencing any of the following conditions:

GENERAL
o Weight Loss or Gain
o Fatigue
o Fever or Chills
o Weakness
o Trouble Sleeping

SKIN
o Rashes
o Lumps
o Itching
o Dryness
o Color Changes
o Hair and Nail Changes

HEAD
o Headache
o Head Injury
o Neck Pain

EARS
o Decreased Hearing
o Ringing in Ears
o Earache
o Drainage

NECK
o Lumps
o Swollen Glands
o Pain
o Stiffness

ENDOCRINE
o Heat or Cold Intolerance
o Sweating
o Frequent Urination
o Thirst
o Change in Appetite

EYES
o Vision Loss/Changes
o Glasses or Contacts
o Pain
o Redness
o Blurry or Double Vision
o Flashing Lights
o Specks
o Glaucoma
o Cataracts

NOSE
o Stuffiness
o Discharge
o Itching
o Hay Fever
o Nosebleeds
o Sinus Pain

MOUTH/THROAT
o Bleeding
o Dentures
o Sore Tongue
o Dry Mouth
o Sore Throat
o Hoarseness
o Thrush
o Non-healing Sores

VASCULAR
o Calf Pain with Walking
o Leg Cramping

HEMATOLOGIC
o Easy Bruising
o Easy Bleeding

BREASTS
o Lumps
o Pain
o Discharge
o Breast Feeding
o Self-Exams

RESPIRATORY
o Cough
o Sputum
o Coughing up Blood
o Shortness of Breath
o Wheezing
o Painful Breathing

CARDIOVASCULAR
o Chest Pain or Discomfort
o Tightness
o Palpitations
o Shortness of Breath with Activity
o Difficulty Breathing when Lying Down
o Swelling
o Sudden Awakening from Sleep with Shortness of Breath

PSYCHIATRIC
o Nervousness
o Stress
o Depression
o Memory Loss

GASTROINTESTINAL
o Swallowing Difficulties
o Heartburn
o Change in Appetite
o Nausea
o Change in Bowel Habits
o Rectal Bleeding
o Constipation
o Diarrhea
o Yellow eyes or skin

URINARY
o Frequent
o Urgent
o Burning or Pain
o Blood in Urine
o Incontinence
o Change in Urinary Strength

MUSCULOSKELETAL
o Muscle or Joint Pain
o Stiffness
o Back Pain
o Redness of Joints
o Swelling of Joints
o Trauma

NEUROLOGIC
o Dizziness
o Fainting
o Seizures
o Weakness
o Numbness
o Tingling
o Tremor