Health & Medical History

Welcome to Nutrition & Diet Counseling Associates. Together we will develop a program that meets your goals and aspirations. We would like to begin by understanding your goals and gathering information about your personal health history. Honest and thorough responses to these questions are essential. All information provided will remain confidential.

Please note that it is strongly recommended that you advise your primary care physician that you are consulting a clinical nutritionist, and that you consult with your physician prior to beginning an exercise program.

Personal Information

Name:
Height:
Occupation:
Who you live with:

Age:
Current Weight:

Family History

1) What was the atmosphere around food like growing up?

2) Is there any family history of chronic illness? (diabetes, heart disease cholesterol, eating disorders) Who?

3) What is the state of health of your immediate family?

Relation	Age	State of Health	Age of Death/Cause
Father			
Mother			
Brothers			
Sisters			

Purpose of Consult

1) What are your long-term and short-term goals of starting nutritional counseling?

2) Have you participated in nutritional counseling before? Please describe

Weight Information

Current Weight: Ave wt for the past 3 years:
Highest adult weight: Age:
Lowest adult weight: Age:
Pre-Pregnancy wt: Post-Pregnancy wt:
Have you lost or gained weight recently?
If yes, when and how much?

What was your weight like throughout childhood and adolescents?

At what weight do you feel the most comfortable?
When were you last at that weight?

What is your current satisfaction level with your body? (Please circle)
Very Satisfied Satisfied Slightly Satisfied Dislike Strongly Dislike

Eating Patterns

1) What special diets have you been on during your lifetime?

2) Are you on a special diet now? If yes, please describe.

3) How many meals per day do you eat? Do you skip any meals? Which ones?

4) Who does most the grocery shopping in your household?

5) Who does most of the cooking in your household?

6) What influences the kinds of foods you buy
❑Price ❑Taste ❑Convince ❑Low calorie ❑Low Fat ❑Low Sugar ❑Other Health Benefits ❑Other:

7) Briefly, what are your snacking habits? (types of foods, frequency, time of day)

8) How often do you eat at the table?

9) How many meals per week do you eat out? Where?

10) How does your lifestyle/schedule influence your eating habits and preferences?

11) Please list your typical daily intake for each:
Breakfast:

Lunch:

Dinner:

Snacks:

Beverages:

12) What are you favorite foods?

13) What foods do you hate?

14) Are there any foods you'd consider binge foods for yourself?

15) Are there any foods you consider to be safe foods for yourself?

16) What foods, if any, do you eat every day?

17) Do you have any food allergies? If so please describe:

18) How often do you eat in your car?
Meals or Snacks? (Please circle)

Vitamin Intake

1) Are you currently taking any type of nutritional supplements (vitamins, mineral, herbs, amino acids, fish oils, etc)?

2) Please list the names of the supplements you are taking

3) Who recommended that you take these supplements?
❑Family Member
❑Advertisement
❑Health Professional
❑Personal trainer
❑Other:

Exercise and Activity

1) Are you currently engaging in any form of exercise? If yes, what kinds and how often?

2) What were your physical activity habits like in the past?

3) What are your feelings towards exercise?

4) Have you informed your primary care physician that you may be beginning a structured exercise regimen?

5) During or after exercise have you ever been:
❑Dizzy or lightheaded
❑Fainted
❑Had chest pain, discomfort, or tightness?
❑Had more difficulty breathing than usual
❑Coughing

Personal Health & Medical History

1) Presently, are you taking any prescribed or over-the-counter medications, vitamins, minerals, or nutritional supplements? If yes, print clearly name(s) of medications, dosages, and frequency of use.

2) Have you ever had any surgeries? If yes please describe

3) Please circle any conditions, signs, symptoms or diseases you now have or have had in the past

osteoporosis	shortness of breath	stroke
dizziness/fainting	chest pain	lactose intolerance
cold hands/feet	anemia	high blood pressure
convulsions/seizure	arthritis	ankle swelling
numbness	diabetes	hear/valve disease
frequent coughing	depression	ulcers
weight control	excess thirst	GI disturbance
sedentary lifestyle	easily fatigued	food sensitivities
hernia	smoking	food allergies
low blood pressure	cancer	
asthma	high cholesterol	

4) Please list any known allergies to medications

5) Do you have any concerns about or unease with your teeth and oral health?

6) Which substances do you currently use?
❑Caffeine ❑Drugs ❑Tobacco ❑Alcohol

7) Which of the above substances did you use regularly in the past? For how long? When did you quit?

8) Currently, are you receiving alternative care from massage therapy, homeopathy, chiropractic, acupuncture, or others?

9) Please list any mental health concerns that I should be aware of (i.e. Depression, anxiety, OCD, PTSD)

10) What is your perceived current level of stress on a scale from 0-10 with 10 being the most stressed out?

11) Sleep: Hours per night?

Any difficulties sleeping?

For Women Only

1) At what age did you start menstruating?

2) Do you have regular menstrual periods?

3) If no, have you stopped completely?

4) Are you currently experiencing any uncomfortable pre-menopause or menopausal symptoms (such as hot flashes, sudden weight gain?) If so please describe:

5) Are you currently pregnant?

6) If yes, how many weeks?

7) Please list your pregnancy history including the year of birth and the sex of the child

I certify that the above information is correct to the best of my knowledge. I will not hold my nutritionist or any member of her staff responsible for any errors or omissions that I may have made in the completion of the form.

_____ _____

SIGNATURE DATE

NUTRITION Rx

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