NUTRITION ASSESSMENT / INTAKE FORM

(Please answer all questions the best you can. You may leave any questions blank that you don't feel comfortable answering. Write "NA" for any question that does not apply to you)

Name: _____ Date: _____

Gender: _____Age: _____ DOB: _____

Referred by: _____ Reason for Referral: _____

Have you ever worked with a Nutrition Therapist/Counselor? ❑ Yes ❑ No

Please list the names of any of the following professionals with whom you are currently working:

Physician: _____ Behavioral Therapist: _____

List all medications you are currently taking: _____

_____

List all vitamin/mineral supplements you are taking: _____

_____

Date of Last Physical Exam: _____ Recent Labs: ❑ Yes ❑ No (please bring any results to visit)

MEDICAL HISTORY: please indicate whether you or a family member have/had any of the following:

Disease/Condition	Self	Family	Relationship / Treatment
Diabetes	❑	❑	_____
Kidney Disease	❑	❑	_____
Cardiovascular Disease	❑	❑	_____
Hypertension	❑	❑	_____
High Cholesterol	❑	❑	_____
Cancer	❑	❑	_____
Obesity	❑	❑	_____
Intestinal problems	❑	❑	_____
Menstrual problems	❑	❑	_____
Osteoporosis	❑	❑	_____
Food Allergies/Intolerances	❑	❑	_____
Mental Health Issues	❑	❑	_____
Drug Dependency	❑	❑	_____
Headaches	❑	❑	_____
Do you drink alcohol?	❑ Yes	❑ No	Number of drinks/wk: _____
Do you smoke?	❑ Yes	❑ No ❑ Quit	Amount/day: _____
Other Medical Concerns	❑	❑	_____

WEIGHT HISTORY:

Do you weigh yourself? ❑ Yes ❑ No How often? _____ Current Height _____

What has been your highest weight ? _____ Age at that time _____ lowest weight ? _____ Age at that time_____

What would you like to weigh? _____ Last time you weighed this? _____ For how long? _____

What is your family's attitude about *health/weight*? _____

MENSTRUAL HISTORY — (males, please skip this section)

Do you currently have menstrual cycles? ❑ Yes ❑ No ❑ Have never menstruated

Age began menstruating: _____ Approximate weight at that time: _____ Height: _____

Date of last menstrual cycle:_____ Average weight fluctuation during menstrual cycle: _____

Have you ever used birth control pills? ❑ Yes ❑ No If yes, for what reason? _____

DIETING HISTORY

How many times have you tried to lose weight? _____ Age at first attempt: _____

Why did you try to lose weight? _____

What have you done in an attempt to control your weight?

Commercial diet programs	❑ Yes	❑ No	_____
Fad diets	❑ Yes	❑ No	_____
Diet pills	❑ Yes	❑ No	_____
Laxatives	❑ Yes	❑ No	_____
Diuretics	❑ Yes	❑ No	_____
Vomiting	❑ Yes	❑ No	_____
Food Restriction	❑ Yes	❑ No	_____
Exercise	❑ Yes	❑ No	_____
Other	❑ Yes	❑ No	_____

_____

EATING PATTERNS

Describe what hunger feels like to you: _____

Describe what fullness feels like to you: _____

How do you know when to stop eating? _____

Do you **usually** eat when you get hungry? ❑ Yes ❑ No

Do you **often** eat when you are not hungry? ❑ Yes ❑ No

Can you tell the difference between physical hunger and "emotional hunger"? ❑ Yes ❑ No

Do you eat standing up?	❑ Yes	❑ No	Do you eat fast?	❑ Yes	❑ No
Do you eat in the car?	❑ Yes	❑ No	Do you eat when lonely?	❑ Yes	❑ No
Do you eat while watching TV?	❑ Yes	❑ No	Do you eat when stressed?	❑ Yes	❑ No
Do you eat while reading?	❑ Yes	❑ No	Do you eat when bored?	❑ Yes	❑ No
Do you eat while on the computer?	❑ Yes	❑ No	Do you eat when anxious?	❑ Yes	❑ No

*Please indicate your **current** eating patterns, check all that apply:*

- ❑ Eat 3 meals each day
- ❑ Eat 3 meals with snacks
- ❑ Eat continuously throughout the day
- ❑ Binge
- ❑ Binge followed by restricting food intake
- ❑ Binge followed by diuretics
- ❑ Binge followed by laxatives
- ❑ Binge followed by vomiting
- ❑ Binge followed by exercise
- ❑ Restrict food intake
- ❑ Restrict with diuretic use
- ❑ Restrict with laxative use
- ❑ Excessive exercise

EATING BEHAVIORS

Please check if you experience any of the following:

❑ Avoid eating a food if you do not know how it was prepared

❑ Avoid eating a food if you do not know it's nutritional content

❑ Won't eat unless you are able to exercise or purge afterward

❑ Become upset if you are unable to eat at a certain time

❑ Become upset if you eat foods other that what you planned

❑ Eat foods that are different from the rest of your family

- ❑ Count calories
- ❑ Count fat grams
- ❑ Count carbohydrate grams
- ❑ Count protein grams
- ❑ Count Weight Watcher points
- ❑ Weigh/ measure your food
- ❑ Cut your food into small pieces
- ❑ Eat faster than others
- ❑ Eat slower than others
- ❑ Refuse to eat after a certain hour
- ❑ Eat the same foods daily
- ❑ Afraid to try new foods
- ❑ Will not eat in front of others
- ❑ Hide food so others will think you ate it
- ❑ Hide food so you can binge
- ❑ Feel guilt after eating
- ❑ Feel ashamed of your eating
- ❑ Believe there are good foods / bad foods
- ❑ Feel food is controlling your life
- ❑ Other_____

EXERCISE HISTORY

Are you currently exercising? ❑ Yes ❑ No Please Describe: _____

_____

Describe your past history with exercise: _____

_____

Do you consider yourself a compulsive exerciser? ❑ Yes ❑ No, If **yes**, please explain _____

_____

Do you have any physical conditions that limit your ability to safely exercise? ❑ Yes ❑ No

If yes, please explain _____

What are your goals for nutrition counseling? Please list and prioritize with #1 as most important.

1._____

2._____

3._____

4._____

5._____

Anything else you would like to share that may impact nutritional therapy? _____

_____