NUTRITION INTAKE FORM – TO BE COMPLETED BEFORE INITIAL NUTRITION CONSULT

PATIENT NAME: ____ DATE: ______________________

OCCUPATION: ____

OTHERS LIVING IN THE HOME (INCLUDE AGES):

____

PRIMARY GROCERY SHOPPER: _________________________FOOD PREPARER: ______________________

CURRENT BODY WEIGHT: ______________________ HEIGHT: _____________________________________

WEIGHT HISTORY: ____

MEDICAL HISTORY – CHECK ALL THAT APPLY:

- € UNINTENTIONAL WEIGHT LOSS/GAIN
- € DIABETES
- € INSULIN RESISTANCE
- € HYPERTENSION
- € ABNORMAL CHOLESTEROL
- € DEPRESSION/ANXIETY
- € VITAMIN/MINERAL DEFICIENCIES
- € IRRITABLE BOWEL SYNDROME
- € SURGERIES RELATED TO THE DIGESTIVE SYSTEM (SUCH AS GASTRIC BYPASS)
- € NUTRIENT MALABSORPTION
- € GASTROESOPHAGEAL REFLUX DISEASE
- € EATING DISORDER

ADDITIONAL COMMENTS:

____

DO YOU HAVE ANY DIFFICULTY CHEWING/SWALLOWING? YES/NO

PLEASE TELL ME ABOUT YOUR BOWEL MOVEMENTS (FREQUENCY, SIZE, COLOR ETC.):

____

PLEASE DESCRIBE THE COLOR OF YOUR URINE, AND DAILY FREQUENCY:

____

WHAT DO YOU HOPE TO ACHIEVE DURING NUTRITION COUNSELING?:

____

____

____

DO YOU CURRENTLY FOLLOW ANY SPECIAL DIET, PLEASE EXPLAIN:

____
____
____

CURRENT SUPPLEMENT USE (IF APPLICABLE):

____

LIST ANY FOOD ALLERGIES, OR INTOLERANCES, PLEASE INCLUDE SYMPTOMS:

____
____

ANY OTHER SELF IMPOSED DIETARY RESTRICTIONS (INCLUDING THOSE RELATED TO RELIGIOUS BELIEFS), PLEASE EXPLAIN:

____
____
____

WHAT EXPERIENCE DO YOU HAVE "DIETING", PLEASE PROVIDE DETAILS:

____
____

WHERE DO YOU CONSUME MOST OF YOUR MEALS, AND UNDER WHAT CONDITIONS (I.E. HOME, AWAY, WITH OTHERS, ALONE, DISTRACTED/MULTI TASKING, OR PRESENT ETC.)

BREAKFAST: ____

LUNCH: ____

DINNER: ____

HAVE YOU WORKED WITH A DIETITIAN/NUTRITIONIST IN THE PAST? YES/NO

IF YES, PLEASE DESCRIBE: ____

IN ORDER TO ASSESS YOUR WILLINGNESS TO CHANGE I ASK THAT YOU RATE YOURSELF ACCORDING TO THE STAGES OF CHANGE. PLEASE PLACE AN X IN THE STAGE YOU MOST CLOSELY IDENTIFY WITH:

- PRECONTEMPLATION - NOT SERIOUSLY THINKING ABOUT CHANGE: _____________
- CONTEMPLATION - CONSIDERING THE POSSIBILITY OF CHANGE: _____________
- PREPARATION – SEE THE BENEFIT OF CHANGE, MAY BE TAKING SMALL STEPS TOWARDS CHANGING BEHAVIOR: _____________
- ACTION - ACTIVELY INVOLVED IN TAKING STEPS TOWARDS CHANGE: _____________
- MAINTENANCE - SUCCESSFULLY AVOID ANY TEMPTATIONS TO RETURN TO PRIOR BEHAVIORS (THOUGH YOU MAY TEMPORARILY SLIP, THIS IS NOT SEEN AS A FAILURE): _____________

CONFIDENCE IN YOUR CURRENT NUTRITION KNOWLEDGE (CIRCLE): POOR / FAIR / GOOD / EXCELLENT

WHAT ADDITIONAL INFORMATION WOULD YOU LIKE TO SHARE THAT MAY HELP ME GET TO KNOW YOU BETTER IN ORDER TO HELP YOU SUCCEED?: ____

____
____

3 DAY DIET JOURNAL

PLEASE EAT AS YOU NORMALLY DO, AND RECORD HONESTLY

DAY 1 DIET JOURNAL

DAY EVENT	FOOD & DRINK INTAKE (INCLUDE TIME OF MEAL, FOOD, AMOUNT, BRAND ETC.)
RISE TIME	
BREAKFAST	
MID- AM SNACK	
LUNCH	
MID-PM SNACK	
DINNER	
PM SNACK	
BED TIME	

DAY 2 DIET JOURNAL

DAY EVENT	FOOD & DRINK INTAKE (INCLUDE TIME OF MEAL, FOOD, AMOUNT, BRAND ETC.)
RISE TIME	
BREAKFAST	
MID- AM SNACK	
LUNCH	
MID-PM SNACK	
DINNER	
PM SNACK	
BED TIME	

DAY 3 DIET JOURNAL

DAY EVENT	FOOD & DRINK INTAKE (INCLUDE TIME OF MEAL, FOOD, AMOUNT, BRAND ETC.)
RISE TIME	
BREAKFAST	
MID- AM SNACK	
LUNCH	
MID-PM SNACK	
DINNER	
PM SNACK	
BED TIME	