Nutrition History

Have you ever had a nutrition consultation before?
_____
Have you made any changes in your eating habits because of your health? Describe:_____
_____
Do you currently follow a special diet or nutritional program?_____
_____

(circle all that apply)
Low Fat Low Carbohydrate High Protein Low Sodium Low Glycemic
No Dairy No Wheat Gluten Free Vegetarian Vegan Other

What is your usual weight?_____ How often do you weigh yourself?_____
What is your desired weight range?_____ Lowest adult weight_____Highest_____
What is your height?_____Waist Circumference?_____ %Bodyfat_____

Do you avoid any particular foods? What and Why?_____
_____

If you could only eat a few foods per week, what would they be?_____
_____
Do you shop for groceries?_____Read labels?_____
Do you cook at home?_____How many meals do you eat out per week?_____

(circle all that apply)
fast eater erratic eating pattern eat to overfull late night eating dislike health food
time constraints eat more than 50% away from home travel frequently poor snacks
non-availability of healthful foods do not plan meals or menus reliance on convenience
significant other or other family member does not like healthful foods love to eat
significant other or family member have special dietary needs or preferences
eat because I have to have a negative relationship to food struggle with eating issues
emotional eater (when sad, lonely, bored…) eat too much under stress
eat too little under stress don't care to cook eat in the middle of the night
confused about nutrition advice

The most important thing I could change about my diet to improve my health is: _____
_____.

Smoking
Currently smoking?_____How many years?_____Packs per day_____
Attempts to quit (when and how):_____
_____
Past smoking: How many years?_____Packs per day_____
Second Hand Smoke Exposure? Childhood_____Recent_____

Alcohol
How many current drinks per week? (1 drink= 5 oz wine, 12 oz beer, 1.5 oz spirits)_____
Previous alcohol intake: (circle) High Moderate Mild None
Have you ever been told you should cut down on your alcohol intake? Yes / No
Do you ever get annoyed when people ask you about your drinking? Yes / No
Do you ever feel guilty about your alcohol consumption? Yes / No
Do you ever take an eye-opener? Yes / No
Do you notice a tolerance to alcohol more than others? Yes / No
Do you notice an intolerance to alcohol compared to others? Yes / No
Have you ever been unable to remember what you did during a drinking episode? Yes / No
Do you get into arguments or physical fights when you have been drinking? Yes / No
Have you ever thought about getting help to to control or stop your drinking? Yes / No

Other Substances
Caffeine intake: form(s)_____ amounts of each_____
Do you take sodas or diet sodas? form(s)_____amounts of each_____
Are you currently using any recreational drugs? form_____ frequency_____
Have you ever used injected recreational drugs?_____

Exercise
Please describe your current exercise regimen (type of activity, duration, frequency):
_____
_____
_____
_____
What is your current level of motivation to include exercise in your life:_____/10
List problems that limit activity:
_____
_____
Do you usually sweat when exercising?_____Feel unusually fatigued afterward?_____

Psychosocial
Do you feel significantly less vital than you did a year ago? Yes / No
Are you happy? Yes / No Do you feel your life has a meaning and a purpose? Yes / No
Do you believe stress is presently reducing the quality of your life? Yes / No
Do you like the work you do? Yes / No Do you feel acknowledged and appreciated? Yes / No
Have you experienced major losses in your life? Yes / No Describe: _____
_____
Do you spend the majority of your time & money to fulfill responsibilities and obligations?Yes/No
Would you describe your experience as a child in your family as happy and secure? Yes / No

Stress/Coping

Have you ever sought counseling? Yes / No Helpful? Yes / No
Are you currently in therapy? Yes / No Describe_____
_____
Do you feel you have an excessive amount of stress in your life? Yes / No
Do you feel you can easily handle the stress in your life? Yes / No
Daily stressors: rate on a scale of 1 - 10
Work_____Family_____Social_____Finances_____Health_____Other_____
Do you practice relaxation or meditation techniques? Yes / No
(circle all that apply): Yoga Meditation Imagery Breathing Tai Chi Prayer Other
Have you ever been abused, a victim of crime, or experienced significant trauma? Yes / No

Sleep/Rest

Average number of hours do you sleep each night? _____
Do you have trouble falling asleep? Yes / No Staying asleep? Yes / No
Do you feel rested upon awakening? Yes / No How many nights is sleep a problem ___/7
Do you snore? Yes / No Have you been told you quit breathing at night? Yes / No
Do you use sleeping aids? Yes / No Describe:_____
_____

Roles/Relationships

Marital Status: Married / Single / Widowed / Divorced / Long term partnership

Full Name of Child	Age	Gender	Health Status	Living in the home?

Resources for emotional support?
(circle all that apply) spouse family friends pet spiritual/religious community
Are you satisfied with your sex life? Yes / No

How well are things going for you?	Very Well	Fine	Poorly	N/A
- overall?				
- at school?				
- in your job?				
- in your social life?				
- with close friends?				
- with sex?				
- with your attitude?				
- with your girlfriend/boyfriend?				
- with your children?				
- with your parents?				
- with your spouse?				

Environmental and Detoxification Assessment

Do you have any known adverse food reactions or sensitivities? Yes / No
Describe:_____
_____
_____

Do you have an adverse reaction to caffeine? Yes / No wired? irritable? aches/pains?

Do you adversely react to (circle all that apply)? MSG Aspartame/NutraSweet Bananas garlic onion cheese citrus foods chocolate alcohol red wine sulfite containing foods (wine, dried fruit, salad bar) preservatives other

Which of these significantly effect you (circle all that apply)? cigarette smoke perfumes/cologne auto exhaust fumes other

In your work or home environment, are you exposed to? Chemicals, Electromagnetic Radiation Mold

Have you ever turned yellow (jaundiced)? Yes / No

Have you ever been told you have Gilbert's syndrome or a liver disorder? Yes / No
Explain:_____

Do you have a known history of significant exposure to any harmful chemicals, such as: herbicides insecticides pesticides organic solvents heavy metals other

Date and length of chemical exposure:_____

Do you dry clean your clothes frequently? Yes / No

Do you or have you lived or worked in a damp or moldy environment or had other mold exposure? Yes / No

Do you have pets or farm animals? Type _____