Patient ID: _____

Nutrition History

Date_____

Please answer each of the questions below. The information you share will help the Registered Dietitian have a better understanding of your needs.

Patient Name: _____ D.O.B: _____

Address: _____

Phone Number: _____ Alternate Number: _____

Email: _____ Can we contact you at this email/Phone? Yes No

Primary Care Physician (PCP): _____ Ethnicity: _____

When did you last see your PCP: _____

1. Are you concerned about your weight?
   - ❑ No (Skip to question 3)
   - ❑ Yes, I want to stop gaining weight.
   - ❑ Yes, I want to lose weight.
   - ❑ Yes, I want to gain weight.
   - ❑ I want to learn how to eat healthy

2. What do you think weighing more/less would do for you?

   In the next few months:

   _____
   _____
   _____

   In the next year or two:

   _____
   _____
   _____

3. What is Your: Age? _____ Body Fat%? _____ Current Weight? _____

   Height? _____ Waist Circum. (iliac crest measured at appointment):_____inches.

4. What is your goal weight? _____ lbs.

5. What was your lowest adult weight? _____ (n/a) Age at this weight? _____

   What was your highest adult weight? _____ (n/a) Age at this weight? _____

5. Do you take any vitamin, mineral, herbal or other dietary supplements (for example protein powders)?
   - ❑ Yes List _____
     _____
   - ❑ No

6. Do you smoke cigarettes?
   - ❑ Yes – How many in a typical day? _____
   - ❑ No

7. Are you currently on a diet or taking prescribed or across-the-counter medication to lose weight or to maintain your current weight?
   - ❑ No
   - ❑ Yes, I am on a diet. Describe the diet.

     _____
     _____
     _____
   - ❑ Yes, I am on these medications:

     _____
     _____
     _____

8. Have you tried to lose weight in the past?
   - ❑ No (Skip to question 10.)
   - ❑ Yes – check all that apply.
     - ❑ Diet(s) Describe.

       _____
       _____
       _____
     - ❑ Medications List.

       _____
       _____
       _____
     - ❑ Other -- Describe.

       _____
       _____
       _____

9. If yes to number 8, did you lose weight?
   - ❑ No
   - ❑ Yes _____ lbs. over this period of time: _____

     How much of this weight, if any, did you gain back? _____ lbs.

     What worked best for you and why?

     _____
     _____
     _____
     _____

10. In the past year, have you tried to lose weight or control your weight by vomiting, taking diet pills or laxatives, or not eating?
    - ❑ Yes
    - ❑ No

11. Do you ever feel that your eating is out of control?
    - ❑ No
    - ❑ Yes – explain:

    _____
    _____
    _____

12. Do you participate in regular physical activity?
    - ❑ No (Skip to question 13.)

    - ❑ Yes -- Describe:

LIST YOUR ACTIVITIES	HOW MANY TIMES A WEEK DO YOU DO THIS ACTIVITY?	HOW MUCH TIME DO YOU SPEND IN THIS ACTIVITY IN A TYPICAL WEEK?
1.		
2.		
3.		
4.		
5.		
6.		

13. Put an X on the line below to show, on a scale from 0 to 10, how important it is for you to make lifestyle changes? (**Lifestyle changes** are changes to improve your health, such as adjusting your diet, increasing your physical activity, and changing health-related behaviors.)

……..
0 5 10

Not very important **Somewhat important** **Very important**

14. Put an X on the line to show how ready you are right now, on a scale of 0 to 10, to make lifestyle changes.

……..

0 5 10

Not very ready **Somewhat ready** **Very ready**

15. Put an X on the line to show how confident you are, on a scale of 0 to 10, that you can make lifestyle changes?

……..

0 5 10

Not very confident **Somewhat confident** **Very confident**

16. What lifestyle changes would you be willing to make?

_____

_____

_____

17. How much time would you be willing to spend each week on making lifestyle changes? (for example attending classes, reading info, tracking foods eaten and activity)

_____

18. What things might make it hard for you to make lifestyle changes?

_____

_____

_____

19. Put an X on the line to show your current level of stress, on a scale of 1 to 5.

1 3 5

…….

Very relaxed **Managing OK** **Very stressed**

20. Describe your family – number of people who live with you and their relationship to you.
    - ❑ Husband, wife, or partner
    - ❑ Children – How many _____, ages_____
    - ❑ Other – Describe:

_____

_____

21. Check any that apply:
    - ❑ My family eats most meals together.
    - ❑ Family meals are served at regular times on most days.
    - ❑ My family is supportive of my efforts to lose weight.
    - ❑ I am on a different diet than the rest of my family.
    - ❑ Another member of my family is on special diet or is trying to lose weight. Describe.

      _____

      _____

22. Check the types of food you and your family eats and how many times in a typical week:
    - ❑ Heat and serve meals _____
    - ❑ Home-cooked meals_____
    - ❑ Fast foods _____
    - ❑ Take out from grocery or restaurant_____

23. Do you need help with learning how to shop for, prepare, and cook your own food?
    - ❑ Yes
    - ❑ No Goals:_____

24. Are you interested in group sessions?
    - ❑ No
    - ❑ Yes

25. Have you read the Masters In Dietetics, L.L.C. HIPAA statement?
    - ❑ No
    - ❑ Yes

26. Email or Phone Number we can leave messages with: _____

Patient Signature: _____ Date: _____

Parent Signature: _____ Date_____

Please check to be sure you have answered all questions and that your name is at the top of each page. Thank you!

For Registered Dietitian use only: BEE: _____ AF: _____

Start BMI: _____ Start Weight: _____Start WC_____ Ending WC: _____ Ending BMI: _____

Nutritional Diagnosis_____ Suggested Cal: _____