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): ____

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:

    ____
    ____

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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 Maters 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: ___________________