Name____ **Date**________________

BACKGROUND QUESTIONS

Physician Information

Physician name: ________________________ Address: ________________________________

Phone: ________________________

Personal Information

Age: ________ Birthdate: __________________ Marital Status: _______________________

Address: ____

Home phone: ______________________ Cell phone: _____________________________

Work phone: ______________________ E-mail: ________________________________

What is your occupation? ________________________ Normal work hours: ____________________

Please list the people in your household and their relationship to you: _____________________________

____

What is the highest level of education you have attended? _____________________________________

What prompted you to seek dietitian services at this time? _____________________________________

What are your personal goals we can help you achieve? ____

How ready are you to make lifestyle changes? (choose #) ________ (Not ready 1 2 3 4 5 Very ready)

OVERALL HEALTH QUESTIONS

Date of your last physical exam: __________________ Date of last blood testing: __________________

How do you rate your health? (check one) ☐ excellent ☐ good ☐ fair ☐ poor

Height: _____________ Current Weight: _____________

What was your lowest body weight as an adult? _____________ Highest? _____________

REVIEW OF SYSTEMS (check all that apply):

Respiratory

☐ Asthma ☐ Sleep apnea ☐ Other:

☐ Emphysema ☐ History of pneumonia _________________

☐ Snoring ☐ Chronic bronchitis

Cardiovascular

☐ High blood pressure ☐ Congestive heart failure ☐ Blood clot

☐ Heart disease/heart attack ☐ Ankle or feet swelling ☐ Other: ________________

CONTINUED (check all that apply): **Initials**______________

Gastrointestinal

- ☐ Nausea/vomiting
- ☐ Abdominal pain
- ☐ Heartburn/GERD
- ☐ Belching
- ☐ Ulcer disease
- ☐ Colitis
- ☐ Constipation
- ☐ Crohn's
- ☐ Diarrhea
- ☐ Gallbladder disease/stones
- ☐ Celiac disease
- ☐ IBS
- ☐ Other: ______________________

Genitouinary

- ☐ Difficulty urinating
- ☐ Urinary incontinence
- ☐ Recurrent urinary infections
- ☐ Infertility
- ☐ Sexual problems
- ☐ Abnormal menstrual period
- ☐ Kidney stones
- ☐ Enlarged prostate
- ☐ Other: ______________________

Musculoskeletal

- ☐ Aching muscles/joints
- ☐ Arthritis
- ☐ Low back pain
- ☐ Vertebral disc problem
- ☐ Torn ligaments/muscle soreness
- ☐ Osteoporosis/Osteopenia
- ☐ Other: ____________________

Endocrine

- ☐ Diabetes Mellitus
- ☐ Thyroid disease
- ☐ Elevated cholesterol
- ☐ Elevated triglycerides
- ☐ Gout
- ☐ Other: ______________________

Skin

- ☐ Infection (boils, ulcers, etc.)
- ☐ Chronic rashes
- ☐ Bruises easily
- ☐ Excessive hair growth (females)
- ☐ Other: ______________________

Other

- ☐ Low energy level
- ☐ Depression, Bipolar, ADD
- ☐ Anxiety disorder, OCD,
- ☐ Panic attacks
- ☐ Psychological/Psychiatric care
- ☐ History of child abuse/rape/molestation
- ☐ History of any physical violence
- ☐ History of cancer
- ☐ Anemia
- ☐ Sickle cell disease
- ☐ Headache
- ☐ Other: ______________________

Do you have family history of the following? (check all) ☐ High Blood Pressure ☐ High Blood Cholesterol

☐ Diabetes ☐ Thyroid Disease ☐ Obesity ☐ Heart Disease

☐ Cancer ☐ Other____

Initials______________

List history of surgeries: ____

Preventative care screenings and diagnostic tests you have had (check all that apply):

- ☐ Sigmoidoscopy/Colonoscopy
- ☐ Mammogram
- ☐ Cardiac Stress Test
- ☐ Prostate/Testicular Exam
- ☐ Bone Density

List current medications and dosages: ____

List current vitamins/supplements: ____

Do you have any allergies or intolerances to medications or foods? _____________________________

How often do you use tobacco? ____________________ How often do you drink alcohol? __________________

Average hours of sleep each night: _________________ Is your sleep restful? ☐ Yes or ☐ No

How would you rate your stress level? (choose #) __________ (Low 1 2 3 4 5 High)

How do you cope with daily stressors? ____

NUTRITION QUESTIONNAIRE

What 1 or 2 things would you like to change about your diet? ______________________________

What eating habits are you most proud of? ____

What eating habits need the most improvement? ____

What foods do you dislike? ____

What foods do you crave? ____

What is your usual eating pattern (check all that apply):

- ☐ varies day to day
- ☐ varies week vs. weekend
- ☐ grazer
- ☐ no pattern/random
- ☐ skip meals
- ☐ nighttime eating
- ☐ 3 meals/day
- ☐ 3 meals + snacks

Who performs the cooking/shopping? ____________________ What grocery store? ______________________

How would you rate your cooking skills? (choose #) __________ (Inexperienced 1 2 3 4 5 Skilled)

Do you read food labels? If yes, what do you look for? ______________________________________

What do you drink with meals and in-between meals? ____

If you snack, what do you usually snack on? ____

How often do you travel? ____

Out of 7 days, how often do you dine out for: Breakfast? __________ Lunch?_________ Dinner? __________

What types of restaurants do you typically frequent? ____

Initials______________

How often do you eat in front of the TV or computer? ____________________________________

What triggers you to eat? (check all that apply)

☐ time of day ☐ hunger ☐ seeing/smelling food ☐ emotions ☐ boredom ☐ other

Do any religious practices or food philosophies affect your diet (ex: Kosher, Vegetarianism)? (describe)

____

Do you eat more rapidly than others? ☐ Yes or ☐ No

Do you eat until feeling uncomfortably full? ☐ Yes or ☐ No

Do you eat large amounts of food when you are not feeling physically hungry? ☐ Yes or ☐ No

Do you eat alone because of being embarrassed by how much you eat? ☐ Yes or ☐ No

Do you feel disgusted, depressed, or guilty after overeating? ☐ Yes or ☐ No

Do you feel that you cannot control the amounts you are eating? ☐ Yes or ☐ No

Do you have a history of the following? (check all that apply)

☐ compulsive over eating ☐ binge eating disorder ☐ anorexia ☐ bulimia ☐ other

What diets have you tried to lose weight? ____

How confident are you about the ***amount*** of current nutrition knowledge you have?________ (Low 1 2 3 4 5 High)

How confident are you about your ability to ***apply*** the nutrition knowledge you have? _______ (Low 1 2 3 4 5 High)

PHYSICAL ACTIVITY QUESTIONNAIRE

What is the most active thing you do in an average day? ______________________________________

What, if any, regular exercise do you participate in? How often? (describe)

____

What physical activity would you like to do that you are currently not doing? ______________________________

If you answer *yes* to any of the following questions, check with your doctor before starting an exercise program:

Has your doctor ever said that you have a heart condition and that you should only do physical activity recommended by a doctor? ☐ Yes or ☐ No

Do you feel pain in your chest or shortness of breath when you do physical activity? ☐ Yes or ☐ No

In the past month, have you had chest pain when you were not doing physical activity? ☐ Yes or ☐ No

Do you lose your balance because of dizziness or do you ever lose consciousness? ☐ Yes or ☐ No

Do you have a bone/joint problem that may worsen by a change in your physical activity? ☐ Yes or ☐ No

Is your doctor currently prescribing drugs for your blood pressure or heart condition? ☐ Yes or ☐ No

Do you know any other reason why you should not do physical activity? ☐ Yes or ☐ No