Nutrition Your Way LLC **Amanda Petty, MS, RD, LDN**

Nutrition Counseling Intake Information

Name_____ Date of first visit_____

Phone # (home)_____(work)_____(cell)_____

E-mail_____ Date of Birth_____

How did you hear about us?_____

What are your most important health concerns? List in order of importance:

1._____

2._____

3._____

4._____

5._____

Medical History:

Height:_____ Weight:_____ Wt. 1 year ago:_____

Usual Wt._____Lowest Wt._____Highest Wt. _____

Desired Wt._____

Have you lost weight or gained weight recently? __ Yes __ No

Was this an intentional change? __ Yes __No

Do you weigh yourself? __ Yes __No How often?_____

Are you concerned about your weight? _____

Do you have any allergies?_____

Please indicate if you or family members have/had any of the following conditions:

Disease/Condition	Self	Family	Relationship	Treatment
Alcoholism				
Anemia				
Anorexia				
Arthritis				
Asthma				
Binge eating				
Bulimia				
Cancer				
Compulsive overeating				
Crohn's disease/colitis				
Depression				
Diabetes				
Food Allergies				
Food Intolerances				
GERD				
Heart disease				
Hepatitis				
High blood pressure				
High cholesterol				
HIV				
Hypoglycemia				
Irritable bowel syndrome				
Kidney disease				
Lupus				
Lyme disease				
Mental illness				
Migraine headaches				
Multiple Sclerosis				
Osteoporosis				
Sleep Apnea				
Stomach/intestinal ulcer				
Stroke				
Substance abuse				
Thyroid disease				
Other				

Are you currently being treated for any medical conditions? __ Yes __No

If yes, please specify._____

Have you had hospitalizations or surgeries? __Yes __No List events and dates:_____

_____

Current Medications:

Name	Dosage	For what?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Nutritional Supplements (such as vitamins):

Name	Dosage	For what?
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you been advised by your physician to follow any special diet? __Yes __No

What type?_____

Are you currently following that diet? __Yes __No

If not, indicate why; If yes, what changes have you made?_____

_____

Do you drink alcohol? __Yes __No Number of drinks per week:_____

Do you smoke cigarettes? __Yes __No Amount per day:_____

How long have you smoked?_____If you quit smoking, when?_____

Do you use recreational drugs? __Yes __No If yes, please explain._____

What is the average amount of sleep you get per night? _____

Dieting History:

How many times have you tried to lose weight?_____

Age of first attempt:_____Your weight at that time:_____

What diet did you follow?_____

Why did you go on that diet?_____

List any other weight loss attempts:

Diet	**Year**	**Outcome**
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you currently restrict food for weight control? __Yes __No

Please explain:_____

Do you currently exercise for weight control? __Yes __No

Please explain:_____

Exercise History:

Do you exercise? __Yes __No Please list type, duration, frequency and intensity of activities:

_____

_____

Have you exercised in the past year? __Yes __No Please list type, duration, frequency and intensity of activities:_____

_____

Do you have any conditions that limit your ability to exercise? __Yes __No

Please specify:_____

Eating Patterns:

How many days per week do you eat each of the following meals?:

Breakfast:_____ Lunch:_____ Dinner:_____

Do you snack? __Yes __No

When?_____What?_____

Do you buy or pack lunches?

____Buy # of days per week:_____ ____Pack # of days per week:_____

How many meals do you eat out per week?_____

What restaurants do you usually choose?

1._____ 2._____ 3._____

4._____ 5._____ 6._____

7._____ 8._____ 9._____

Who prepares the food at home?_____

Do you know how to cook? __ Yes __ No

Who does the grocery shopping? _____

Do you read food labels? __ Yes __ No What do you look for on the label?_____

_____

Do you eat standing up? __Yes __No Do you eat in the car? __Yes __No

Do you eat while watching TV? __ Yes __No Do you eat at the computer? __Yes __No

Do you eat with others? __ Yes __No Do you eat fast? __Yes __No

Do you eat when you are bored? __Yes __ No Do you eat when stressed? __Yes __No

Do you eat when not hungry? __ Yes __No Avoid certain foods? __Yes __No

What are your favorite foods?_____

_____

Do you avoid any foods or food textures? _____

Do you want to change your eating habits? __Yes __No Why?_____

_____

Do you have any expectations about coming to see a dietitian?_____

_____