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One's health and well-being are influenced by many different things, including lifestyle, family history, emotional health, and nutrition/eating habits. Please complete the following questionnaire to the best of your ability to give us an overall view of your general lifestyle and health habits.

New Patient Nutrition Assessment Form

First Name _____Middle Name_____Last Name_____

Address _____ City _____State_____Zip:_____

Please indicate your preferred method of contact: home work cell email

Home Phone (_____)_____-_____ Birth Date _____/_____/_____ Age _____

Work Phone (_____)_____-_____ Email address: _____

Cell Phone (_____)_____-_____ Height: ___' ____ " Weight: _____ Sex: _____

Blood Type (Please circle): A / AB / B / O / Unk

Occupation _____ Marital Status _____

Do you have children? Yes No Age of children_____

Are you pregnant? Yes No Due Date_____

With whom do you live? (Include children, parents, relatives, and/or friends. Please include ages.)
Example: Sarah, age 7, sister

_____

_____

Primary Care Provider _____ Date of last physical exam _____

Other doctors or practitioners you see _____

Would you like to receive e-mail notifications regarding cooking classes/demonstrations? _____

If yes, please sign _____

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GOALS AND READINESS ASSESSMENT

I would like to visit with the dietitian, today because…

_____
_____
_____

My food and nutrition-related goals are…

_____
_____
_____

My overall, health goals are…

_____
_____
_____

If I could change three things about my health and nutritional habits, they would be…

1. _____
   _____
2. _____
   _____
3. _____
   _____

The biggest challenge(s) to reaching my nutrition goals is/are:

_____
_____
_____

In the past, I have tried the following techniques, diets, behaviors, etc. to reach my nutrition goals…

_____
_____
_____

On a scale of 1 (not willing) to 5 (very willing), please indicate your readiness/willingness to do the following:

To improve your health, how ready/willing are you to…	1	2	3	4	5
Significantly modify your diet					
Take nutritional supplements each day					
Keep a record of everything you eat each day					
Modify your lifestyle (ex: work demands, sleep habits, physical activity)					
Practice relaxation techniques					
Engage in regular exercise/physical activity					
Have periodic lab tests to assess your progress					

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PAST MEDICAL AND SURGICAL HISTORY

Please indicate whether you or your relatives* have been diagnosed with any of the following diseases or symptoms (specify which relative and the date of diagnosis). *Relatives include: parents, grandparents, siblings.

	Illness/Disease/Symptom	Self: Age Diagnosed	Relative: Age Diagnosed	Describe/Specify
☐	Allergies (please specify type of allergy)			
☐	Anemia			
☐	Anxiety or Panic Attacks			
☐	Arthritis (osteoarthritis or rheumatoid)			
☐	Asthma			
☐	Autoimmune condition (specify type)			
☐	Bronchitis			
☐	Cancer			
☐	Chronic Fatigue Syndrome			
☐	Crohn's Disease or Ulcerative Colitis			
☐	Depression			
☐	Diabetes (Specify: Type I, II, Prediabetes, Gestational Diabetes)			
☐	Dry, itchy skin, rashes, dermatitis			
☐	Eczema			
☐	Emphysema			
☐	Epilepsy, convulsions, or seizures			
☐	Eye Disease (please specify)			
☐	Fibromyalgia			
☐	Food Allergies or Sensitivities			
☐	Fungal Infection (athlete's food, ringworm, other)			
☐	Gallbladder Disease/Gallstones (specify)			
☐	Gout			
☐	Heart attack/Angina			
☐	Heartburn			
☐	Heart disease (specify)			
☐	Hepatitis			
☐	High blood fats (cholesterol, triglycerides)			
☐	High blood pressure (hypertension)			
☐	Hypoglycemia (low blood sugar)			
☐	Intestinal Disease (specify)			
☐	Infammatory Bowel Disease (Crohn's or Ulcerative Colitis)			
☐	Irritable bowel syndrome			
☐	Kidney disease/failure or Kidney stones			
☐	Lung disease (specify)			
☐	Liver disease			
☐	Mononucleosis			
☐	Osteoporosis			
☐	PMS			
☐	Polycystic Ovarian Syndrome			

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Illness/Disease/Symptom	Self: Age Diagnosed	Relative: Age Diagnosed	Describe/Specify
☐ Pneumonia			
☐ Prostate Problems			
☐ Psychiatric Conditions			
☐ Seizures or epilepsy			
☐ Sinusitis			
☐ Sleep apnea			
☐ Stroke			
☐ Thyroid disease (hypo- or hyperthyroid)			
☐ Urinary Tract Infection			
☐ Other (describe)			
Injuries	**Age**	**Describe/Specify**	
☐ Back injury			
☐ Broken (specify)			
☐ Head injury			
☐ Neck injury			
☐ Other (describe)			
Diagnostic Studies	**Age at study**	**Describe/Specify**	
☐ Barium Enema			
☐ Bone Scan			
☐ CAT Scan: Abdom., Brain, Spine (specify)			
☐ Chest X-ray			
☐ Colonoscopy or Sigmoidoscopy (specify)			
☐ EKG			
☐ Liver scan			
☐ NMR/MRI			
☐ Upper GI Series			
☐ Other (describe)			
Operations	**Age at operation**	**Describe/Specify**	
☐ Dental Surgery			
☐ Gall Bladder			
☐ Hernia			
☐ Hysterectomy			
☐ Tonsillectomy			
☐ Other (describe)			

Please complete the following information concerning your family's health history:

	If Living		If Deceased			If Living		If Deceased	
	Age	Health	Age at death	Cause		Age	Health	Age at death	Cause
Father					**Spouse/Partner**				
Mother					**Children**				
Siblings									

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MEDICAL SYMPTOMS QUESTIONNAIRE

Rate each of the following symptoms based upon your typical health profile for the past 30 days. If you have been having recent or somewhat severe health symptoms, please indicate that you will fill out the questionnaire for the past 48 hours.

☐ *Past 30 days* ☐ *Past 48 hours*

Point Scale

0 – *Never* or *almost never* have the symptom
1 – *Occasionally* have it, effect is *not severe*
2 – *Occasionally* have it, effect is *severe*
3 – *Frequently* have it, effect is *not severe*
4 – *Frequently* have it, effect is *severe*

HEAD

_____Headaches
_____Faintness
_____Dizziness
_____Insomnia

Total _____

EYES

_____ Watery or itchy eyes
_____ Swollen, reddened or sticky eyelids
_____ Bags or dark circles under eye
_____ Blurred or tunnel vision
(does not include near or far-sightedness)

Total _____

EARS

_____ Itchy ears
_____ Earaches, ear infections
_____ Drainage from ear
_____ Ringing in ears, hearing loss **Total _____**

NOSE

_____ Stuffy nose
_____ Sinus problems
_____ Hay fever
_____ Sneezing attacks
_____ Excessive mucus formation **Total _____**

MOUTH/THROAT

_____ Chronic cough
_____ Gagging, frequent need to clear throat
_____ Sore throat, hoarseness, loss of voice
_____ Swollen or discolored tongue, gums, lips
_____ Canker sores **Total _____**

SKIN

_____ Acne
_____ Hives, rashes, dry skin
_____ Hair loss
_____ Flushing, hot flashes
_____ Excessive sweating **Total _____**

HEART

_____ Irregular or skipped heartbeat
_____ Rapid or pounding heartbeat
_____ Chest pain **Total _____**

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LUNGS _____ Chest congestion
_____ Asthma, bronchitis
_____ Shortness of breath
_____ Difficulty breathing **Total _____**

DIGESTIVE TRACT
_____ Nausea, vomiting
_____ Diarrhea
_____ Constipation
_____ Bloated feeling
_____ Belching, passing gas
_____ Heartburn
_____ Intestinal/stomach pain **Total _____**

JOINT/MUSCLE
_____ Pain or aches in joints
_____ Arthritis
_____ Stiffness or limitation of movement
_____ Pain or aches in muscles
_____ Feeling of weakness or tiredness **Total _____**

WEIGHT
_____ Binge eating/drinking
_____ Craving certain foods
_____ Excessive weight
_____ Compulsive eating
_____ Water retention
_____ Underweight **Total _____**

ENERGY/ACTIVITY
_____ Fatigue, sluggishness
_____ Apathy, lethargy
_____ Hyperactivity
_____ Restlessness **Total _____**

MIND _____ Poor memory
_____ Confusion, poor comprehension
_____ Poor concentration
_____ Poor physical coordination
_____ Difficulty in making decisions
_____ Stuttering or stammering
_____ Slurred speech
_____ Learning disabilities **Total _____**

EMOTIONS
_____ Mood swings
_____ Anxiety, fear, nervousness
_____ Anger, irritability, aggressiveness
_____ Depression **Total _____**

OTHER _____ Frequent illness
_____ Frequent or urgent urination
_____ Genital itch or discharge **Total _____**

GRAND TOTAL _____

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MEDICATION, SUPPLEMENT, AND ANTIBIOTIC INTAKE: Please provide the names of medications, supplements, and/or antibiotics that you are currently taking:

Medication/Supplement/ Antibiotic	Dose	Units	Frequency	Start Date	Stop Date
Example: One-a-Day (brand) Men's Multivitamin	1200	Mg	Daily	08/12/2007	current

Are you allergic to any medications? Yes No Please list: _____

Please indicate how often you have taken antibiotics during each life stage:

	< 5 times	> 5 times
Infancy/ Childhood		
Teen		
Adulthood		

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LIFESTYLE

Physical Activity: Using the table, please describe your physical activity.

Activity	Type/Intensity (low-moderate-high)	# Days per week	Duration (minutes)
Stretching/Yoga			
Cardio/Aerobics (walking, jogging, biking, etc.)			
Strength-training (weight lifting, pilates, some yoga)			
Sports or Leisure			
Other (specify/describe)			

Does anything limit you from being physically active?

_____

Indicate daily stressors and rate the level of stress from 1 (extremely low) to 10 (extremely high):

□Work_____ □Family_____□Social_____□Financial_____□Health_____ Other_____

What helps you to unwind?_____

On average, how many hours of sleep do you get? Weekdays_____ Weekends_____

Do you smoke? ☐ Never ☐ In the past ☐ Currently How long?_____

Alcohol use ☐ Never ☐ In the past ☐ Currently Type/amount/frequency_____

Drug use ☐ Never ☐ In the past ☐ Currently ☐ Prefer not to discuss Type/frequency_____

WEIGHT HISTORY:

Would you like to be weighed today? ☐ Yes ☐ No

Height _____ Current Weight _____ Desired Body Weight _____

Highest Adult Weight _____ When? _____ Weight 1 year ago _____

Have you had any recent changes in your weight that you are concerned about? ☐ Yes ☐ No

If yes, please explain:_____

DIGESTIVE HISTORY

- Do you associate any digestive symptoms with eating certain foods? ☐ Yes ☐ No
- Please explain:_____
  _____ _____
- How often do you have a bowel movement? _____
- If you take laxatives, what type/brand and how often?
  _____

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- Would you describe your stools are hard, soft, or loose? (circle one)
- Please indicate how often you experience the following symptoms:

Heartburn	Often	Sometimes	Rarely
Gas	Often	Sometimes	Rarely
Bloating	Often	Sometimes	Rarely
Stomach Pain	Often	Sometimes	Rarely
Nausea/Vomiting	Often	Sometimes	Rarely
Diarrhea	Often	Sometimes	Rarely
Constipation	Often	Sometimes	Rarely

DIET HISTORY

Do you follow any special diet or have diet restrictions or limitations for any reason (health, cultural, religious or other)? ☐Yes ☐No If so, please describe _____

Please list any food allergies, sensitivities or intolerances _____

_____

Who prepares the majority of your meals? _____ Who shops for food? _____

Where do you shop for food? _____

What percent of the foods you eat are… whole _____% organic_____% convenience _____%

If you do, how much time do you spend cooking/preparing meals each day? _____

Please indicate the materials you use for cooking and food storage:

☐Plastic ☐Glass ☐Aluminum ☐Styrofoam

☐Stainless Steel ☐Cast-iron ☐Teflon/non-stick ☐ Ceramic

Do you find cooking difficult? ☐Yes ☐No Please describe _____

INTAKE INFORMATION:

If you follow a special diet/nutritional program, check the following that apply:

☐Low Fat ☐Low Carb ☐High Protein ☐Low Sodium

☐No Gluten ☐Vegetarian ☐Vegan ☐Diabetic

☐No Dairy ☐No Wheat ☐Weight Loss ☐Other

_____

Which meals do you eat regularly, check all that apply:

☐Breakfast ☐Lunch ☐Dinner/Supper ☐Snacks (time _____)

The nutrition/eating habits that are most challenging for me: _____

_____

_____

The nutrition/eating habits that I am most pleased with: _____

_____

_____

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Beverage Intake: Please indicate the beverages you drink, and how often you drink them. Fill in the "Daily Amount", "Weekly Amount", and/or "Monthly Amount"

Beverage Type	Daily Amount	Weekly Amount	Monthly Amount
Example: Coffee: X reg ☐decaf ☐latte	2 – 8 oz cups	—	—
Water: ☐tap ☐filtered ☐bottled			
Coffee:☐reg. ☐decaf. ☐latte			
Tea: what type(s)?_____			
Juice: ☐Natural ☐Fruit drinks			
Soda: ☐regular ☐diet			
Milk: ☐whole ☐2% ☐1% ☐skim			
Milk alternative Type_____			
Alcohol: ☐wine ☐beer ☐liquor			
Other _____			

Food Intake: Please indicate the frequency that you eat the following:

How often do you eat:	Never	2-3 times/mo.	1 time/week	2-3 times/week	1 times/day	2-3 time/day
Fast food						
Restaurant food						
Vending machine food						
Cafeteria or buffet food						
Frozen meals						
Home-cooked meals						
Leftovers						
Beef (hamburger, steak, etc.)						
Pork (chop, loin, ham, bacon, etc.)						
Liver						
Lamb						
Poultry (chicken, turkey, etc.)						
Deli meat, type:						
Fish, type:						
Soyfoods, type:						
Beans, type:						
Crackers, type:						
Cookies, cakes, muffins						
Whole grains, type:						
Fresh/Raw vegetables						
Cooked vegetables						
Fruit, fresh or frozen						
Canned Vegetables or Fruit						
Margarine						
Dairy (Milk, yogurt, cheese, butter)						
French fries						
Fried meat (chicken, fish)						
Foods with added sweeteners/sugar, type:						
Artificial sweeteners, type:						
Meal Replacements, type:						

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Food cravings

_____

Food dislikes

_____

Eating Style: Based on how you eat on a regular basis, please check all that apply:

☐Fast Eater	☐Family member(s) have different tastes
☐Erratic eater	☐Love to eat
☐Emotional eater (stressed, bored, sad, etc.)	☐Eat too much
☐Late night-eater	☐Eat because I have to
☐Time constraints	☐Negative relationship with food
☐Dislike "healthy" food	☐Struggle with eating issues
☐Travel frequently	☐Confused about food/nutrition
☐Do not plan meals/menus	☐Frequently eat fast food
☐Rely on convenience items	☐Poor snack choices

The food/nutrition questions that I would like to ask are:_____

_____

_____

_____

_____

_____

_____

_____