Nutrition Consultation Form

CLIENT INFORMATION:

Name: _____ Date: _____

Date of Birth: _____ Height: ____ (feet) ____ (inches)

Current Body Weight: _____ Desired Body Weight: _____

Lowest Body Weight: _____ Highest Body Weight: _____

Major: _____ Year at Bentley: _____

Extra-Curricular Activities / Sports: _____

_____

Physician: _____ Phone: _____

NUTRITION AND FITNESS GOALS:

What are your nutrition and fitness goals?

1. _____
2. _____
3. _____
4. _____
5. _____

What have you tried in the past to achieve your nutrition and fitness goals? This includes any diet or exercise program, supplement use, books, etc…

1. _____
2. _____
3. _____
4. _____
5. _____

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Clinical Dietician

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MEDICAL HISTORY AND MEDICATIONS:

Please list any relevant past medical history and current medications:
I.e. food allergies/intolerances, high cholesterol, diabetes, heart disease, ADHD, hypo/hyperthyroidism, recent surgeries, bowl disease, depression, eating disorders, recent athletic injuries, anemia, etc…

_____

_____

_____

Have you ever been diagnosed with an eating disorder? Yes or No

At what age did you get your first period? _____

Do you get regular periods? Yes or No

When was your last menstrual period? _____ How long did it last? _____

Do you take any Vitamin / Mineral supplements? Yes or No If yes, please list below:

_____

_____

Are there any foods that you avoid? Yes or No If yes, please list below:

_____

_____

Are you a Vegetarian? Yes or No If yes, please circle which foods you **DO NOT** eat:

chicken fish dairy eggs red meat

On average, how many days a week do you consume alcoholic beverages?

0 1 2 3 4 5 6 7

On average, how many alcoholic drinks do you consume at one time?

0 1 2 3 4 5 6 7 8 9 10 11 12+

What types of alcohol do you consume?

Beer Wine Liquor Other

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On average, how many caffeinated beverages do you consume per day?

0 1 2 3 4 5 6 7 8 9 10 11 12+

What types of caffeinated beverages do you consume?
I.e. energy drinks, coffee, tea, soda, etc.

_____

_____

Do you smoke (tobacco products)? Yes or No If yes, how many cigarettes per day?

0 1 2 3 4 5 6 7 8 9 10 11 12+

On average, about how many hours do you sleep: Weeknights _____ Weekends _____

Are you stressed? Yes or No If yes, how stressed are you? Please circle

1	2	3	4	5
Not at all	**A little**	**Moderate**	**Very**	**Extremely**

How do you manage your stress?

_____

_____

_____

_____

Have you seen a counselor / therapist in the past, or are you working with someone presently?

_____

_____

_____

_____

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EXERCISE:

Are you currently on an exercise program? Yes or No

If so, what specifically are you doing each day?

Sunday: _____

Monday: _____

Tuesday: _____

Wednesday: _____

Thursday: _____

Friday: _____

Saturday: _____

Are you currently working with a Trainer or Coach? Yes or No If yes, who and when?

_____

_____

_____

Have you ever played a sport? Yes or No If yes, which sport(s), when, and how long?

_____

_____

_____

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NUTRITION LOG:

What did you eat and drink yesterday? Please include portion sizes and brands if it is possible.
I.e. 1 cup of Tropicana orange juice, 6 ounces Non Fat Dannon Yogurt, etc…

Breakfast: Time: _____

Item(s): _____

_____

Morning Snack: Time: _____

Item(s): _____

_____

Lunch: Time: _____

Item(s): _____

_____

Afternoon Snack: Time: _____

Item(s): _____

_____

Dinner: Time: _____

Item(s): _____

_____

Snack/Dessert: Time: _____

Item(s): _____

_____

Exercise: _____

_____

_____

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NOTES:

S:

O:

A/P:

Jennifer Murphy MS, RD, LDN
Clinical Dietician