FEEL GOOD NUTRITION

DIET & NUTRITION COUNSELING

Alec Smith
Registered Dietitian / Nutritionist

Dietitian History Questionnaire and Assessment

General Information:

Name: ______________________________ Today's Date: ____________

Occupation: ____

Age: __________ Date of Birth: ____________________ Gender: __________

Reason for Appointment: ______________________________________

____

____

____

Primary Care Provider: ____

____

Address/Phone: ____

____

Medical History:

Height: ____________________ Current Weight: ____________________

____

____

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 drugs? ___ Yes ___ No Explain: ____________________

____

List any medications you are currently taking or have taken in the last year:

1. ____________________ 2. ____________________

3. ____________________ 4. ____________________

5. ____________________ 6. ____________________

7. ____________________ 8. ____________________

9. ____________________ 10. ____________________

Are you currently taking any food or nutritional/herbal supplements? ___ Yes ___ No

If yes, please specify: _______________________________________

____

____

____

Please indicate whether you or a family member have/had any of the following conditions:

Disease/Condition	Self	Family	Relationship	Treatment
Asthma	______	______	______________	______________________________
Cancer	______	______	______________	______________________________
Cardiovascular Disease	______	______	______________	______________________________
Diabetes	______	______	______________	______________________________
Drug Dependency	______	______	______________	______________________________
Eating Disorder	______	______	______________	______________________________
Food Allergies	______	______	______________	______________________________
Food Intolerances	______	______	______________	______________________________
Kidney Disease	______	______	______________	______________________________
High Cholesterol	______	______	______________	______________________________
High Blood Pressure	______	______	______________	______________________________
Intestinal Problems	______	______	______________	______________________________
Menstrual Problems	______	______	______________	______________________________
Osteoporosis	______	______	______________	______________________________

Other ____

____

____

____

Are you currently being treated for any medical conditions? ___ Yes ___ No

If yes, please specify: ____

Have you ever been advised by your physician to follow a special diet? ___ Yes ___ No

If yes, please specify: ____

____

____

Are you currently following that diet? ___ Yes ___ No

If not, why? If yes, what changes have you made? ____________________________

Weight/Dieting History:

Have you tried to lose weight before? ___ Yes ___ No

How many times? ____________________ Age of first attempt: _____ years

What did you do? ____

Why did you go on that diet? ____

____

Do you experience periods during which you eat uncontrollably? ___ Yes ___ No

If yes, how often? ____

Is this followed by:

_____ Vomiting How often? ______________________________________

_____ Laxative use How often? ______________________________________

_____ Excessive exercisin How often? ______________________________________

_____ Self harm How often? ______________________________________

_____ Negative emotions How often? ______________________________________

_____ Other (explain) ____

Weight/Dieting History, Continued:

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

If yes, please explain: ____________________

Are you currently or have you ever received treatment? ___ Yes ___ No

If yes, please explain: ____________________

____

Do you currently exercise for weight control? ___ Yes ___ No

Please explain: ____________________

Exercise History:

Do you exercise? _____ Yes _____ No

Please explain: ____________________

If so, how often? ___ Daily ___ Every Other Day ___ Twice Per Week ___ One Per Week ___ Rarely

Type of Exercise? ___ Walking ___ Areobics ___ Dance ___ Running ___ Cycling ___ Team Sports

___ Yoga ___ Weight Lifting ___ Swimming ___ Tennis ___ Racket Ball ___

___ Rowing ___ Hiking ___ Rollerblade ___ Pilates ___ Tai Chi

Other, Please explain: ____________________

Eating Habits:

Do you skip meals? ___ Yes ___ No

How many days per week do you eat:

Breakfast: _____ Lunch: _____ Dinner: _____

Do you snack? ___ Yes ___ No

If so, when? ____________________

Do you buy or pack your lunches?

___ Buy # days per week: ___ ___ Pack # days per week: ___

Do you eat out? ___ Yes ___ No

How many meals per week? ____________________

What restaurants do you usually choose?

1. ______ 4. ______ 7. ______

2. ______ 5. ______ 8. ______

3. ______ 6. ______ 9. ______

Who usually prepares the food at home? ____________________

Who does the grocery shopping? ____________________

Please specify how many of the follow you drink *per week*:

_______ alcohol _______ diet soft drinks _______ regular soft drinks

_______ caffeinated coffee _______ fruit juice _______ regular tea

_______ decaf coffee _______ green tea _______ sports drinks

_______ diet drinks/aids _______ herbal tea _______ water

Please indicate any beverages that are not listed that you consume regularly ____________________

____

Eating Habits, Continued:

What foods do you crave? ____________________

What foods do you avoid? ____________________

Why? ____________________

Do you snack during the day? ☐ Yes ☐ No If yes, please describe ____________________

____

Do you have good energy levels? ☐ Yes ☐ No ☐ Inconsistent Does napping help? ☐ Yes ☐ No

Can you attribute low energy to anything in particular? ☐ Yes ☐ No

If yes, please specify ____________________

Do you consider yourself ☐ Underweight ☐ Overweight ☐ Just Right

Sleep Time you normally go to bed __________ Fall asleep __________ Awaken for the day ________

How many hours of sleep do you need to feel rested? __________ How many do you get? ________

Goals/Expectations

Do you want to change your eating habits? ___ Yes ___ No

Why? ____________________

____

Did you have any expectations from coming to see the nutritionist today? ___ Yes ___ No

Please explain: 5111 E 65th St. • Indianapolis, IN 46220-4816 ____________________

***It is helpful for our Nutritionists to have ample time to review your information. If possible, please send your paperwork at least one day prior to your scheduled appointment. Thank You!