Nutrition Your Weigh!
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# Dietitian History Questionnaire and Assessment

**General Information:**

Name: _____ Today's Date: _____

Occupation: _____ ___ Full time ___ Part time

Place of Employment: _____

Address: _____

Phone: _____ Phone #2: _____ Email: _____

Age: _____ Date of Birth: _____ Gender: _____

Reason for Appointment: _____

_____

_____

_____

Primary Care Provider: _____

_____

Address/Phone: _____

_____

Therapist: _____

_____

Address/Phone: _____

_____

Education level: ____Grammar School _____ High School _____ College _____ Graduate School

Marital Status: ___ Single ___ Married ___ Divorced ___ Separated ___ Widowed

Number of Children: _____

Age: _____ Date of Birth: _____ Gender: _____

Age: _____ Date of Birth: _____ Gender: _____

Age: _____ Date of Birth: _____ Gender: _____

Age: _____ Date of Birth: _____ Gender: _____

Age: _____ Date of Birth: _____ Gender: _____

**Medical History:**

Height: _____ Current Weight: _____

***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 | | | | |
| Headaches | | | | |
| Heart Attack | | | | |
| High Cholesterol | | | | |
| Hypertension | | | | |
| Intestinal Problems | | | | |
| Menstrual Problems | | | | |
| Mental Health Issues | | | | |
| Obesity | | | | |
| Osteoporosis | | | | |

Other _____

_____

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

If yes, please specify: _____

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: _____

_____

_____

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? _____

_____

_____

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: _____

_____

**Menstrual History:** (Female Patient):
Are you currently menstruating? ___ Yes ___ No _____Have never menstruated
At what age did you get your first period? _____
Date of last menstrual cycle: _____ Weight at that time: ____ pounds
Are your periods regular? ___ Yes ___ No
Are you taking birth control pills / estrogen pills? ___ Yes ___ No
Do you experience PMS? ___ Yes ___ No
If yes, what are your symptoms? _____

_____

**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? _____

_____

Have you ever used any of the following for weight control? If yes, please explain.
Commercial diet programs ____ Yes ____ No _____
Liquid diets ____ Yes ____ No _____
Fad diets ____ Yes ____ No _____
Prescription diet pills ____ Yes ____ No _____
Over-the-counter diet pills ____ Yes ____ No _____
Laxatives ____ Yes ____ No _____
Diuretics ____ Yes ____ No _____
Ipecac syrup ____ Yes ____ No _____
Vomiting ____ Yes ____ No _____
Self-designed program ____ Yes ____ No _____
Other _____
Do you experience periods during which you eat uncontrollably? ___ Yes ___ No
If yes, how often? _____
At what age did this begin? _____ years
Is this followed by:
_____ Vomiting Age began:_____ How often? _____
_____ Laxative use Age began:_____ How often? _____
_____ Excessive exercising Age began:_____ How often? _____
_____ Self harm Age began:_____ How often? _____
_____ Negative emotions Age began:_____ How often? _____
_____ Other (explain) _____
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: _____

Do you have any physical conditions that limit your ability to exercise? ___ Yes ___ No
Please specify: _____

**Family Weight History:**
Are any members of your family overweight? ___ Yes ___ No
Please explain: _____
Are any members of your family underweight? ___ Yes ___ No
Please explain: _____
Does anyone in your family diet? ___ Yes ___ No
Please explain: _____
Did/Does anyone in your family have an eating disorder? ___ Yes ___ No
Please explain: _____
Does your family eat meals together? ___ Yes ___ No
What meals? _____
What is this like? _____

**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? _____
Do you know how to cook? ___ Yes ___ No
Who does the grocery shopping? _____
Do you read food labels? ___ Yes ___ No What do you look at on the label? _____

_____

Do the nutrition facts influence your decision to eat the food? ___ Yes ___ No
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 while reading or on the computer? ___ Yes ___ No
Do you eat with others? ___ Yes ___ No
Do you eat fast? ___ Yes ___ No
Do you eat when bored? ___ Yes ___ No
Do you eat when stressed? ___ Yes ___ No
Do you eat when you are anxious? ___ Yes ___ No
Do you eat when you are lonely? ___ Yes ___ No
Do you eat when you are hungry? ___ Yes ___ No
Do you eat when you are not hungry? ___ Yes ___ No
Do you avoid certain foods? ___ Yes ___ No
If yes, please specify: _____
What are your favorite foods? _____

**Malnutrition Symptoms:**

Do you now or have you ever experienced (for each checked, please add details to explain):

_____ Irregular menstrual periods _____
_____ Absent menstrual periods _____
_____ Cold intolerance _____
_____ Tingling sensation in hands or feet _____
_____ Headaches _____
_____ Lightheadedness/Dizziness _____
_____ Fainting _____
_____ Sleeping difficulties _____
_____ Skin changes _____
_____ Hair loss _____
_____ Hair growth on face and/or chest _____
_____ Chest pains _____
_____ Rapid heart beat _____
_____ Shortness of breath _____
_____ Mood swings _____
_____ Episodes of crying for “no reason” _____
_____ Frequently thinking about food _____
_____ Confusion _____
_____ Difficulty concentrating _____
_____ Anxiety, especially around food _____
_____ Less social interaction with family _____
_____ Frequently tired _____
_____ Memory problems _____
_____ Difficulty making decisions _____
_____ Problems with teeth

_____ Sore throat _____

_____ Swollen parotid glands _____

_____ Taste changes _____

_____ Constipation _____

_____ Diarrhea _____

_____ Muscle pain _____

_____ Joint pain _____

_____ Obsessive-compulsive behaviors _____

_____ Feelings of depression _____

_____ Other (explain) _____

**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: _____

# Food Frequency Checklist

Patient's Name: _____ Date: _____

| Check the Frequency the Following Foods are Consumed | Never or Less than Once per Week | 1-2 Times per Week | 3-7 Times per Week | More than Once a Day |
|---|---|---|---|---|
| Beef | | | | |
| Sausage, Bacon, Lunchmeat | | | | |
| Pork | | | | |
| Poultry | | | | |
| Poultry – Prebreaded, e.g. nuggets | | | | |
| Poultry – Fried | | | | |
| Fish | | | | |
| Fish – Prebreaded, e.g. fish sticks | | | | |
| Fish – Fried | | | | |
| Shellfish | | | | |
| Beans | | | | |
| Peanut Butter | | | | |
| Pizza | | | | |
| Milk (Specify Type) | | | | |
| Cream | | | | |
| Cheese | | | | |
| Cheese – Regular | | | | |
| Cheese – Low Fat | | | | |
| Cheese – Non-Fat | | | | |
| Yogurt | | | | |
| Ice Cream | | | | |
| Frozen Yogurt | | | | |
| Eggs | | | | |
| Oils | | | | |
| Butter | | | | |
| Margarine | | | | |
| Vegetables | | | | |
| Fruits | | | | |
| Fruit Juice | | | | |
| | | | | |
| | | | | |
| | | | | |

| Check the Frequency the Following Foods are Consumed | Never or Less than Once per Week | 1-2 Times per Week | 3-7 Times per Week | More than Once a Day |
|---|---|---|---|---|
| Breads | | | | |
| Cereals | | | | |
| Pasta, Noodles, Rice, Etc. (cup) | | | | |
| Potatoes | | | | |
| Commercial Baked Goods (cookies, donuts, cakes, etc.) (Serving) | | | | |
| Cookies | | | | |
| Soft Drinks (Non-Diet) (Serving) | | | | |
| Snack Crackers (Serving) | | | | |
| Nuts and Seeds (1/4 Cup) | | | | |
| Potato Chips or Corn Chips (Cup) | | | | |
| Sherbets and Ices (1/2 Cup) | | | | |
| Candy | | | | |
| Frozen Meals | | | | |
| Chinese Food | | | | |
| Fast Food | | | | |
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