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				