MK *Plus*

Nutrition Counseling

Nutrition History Questionnaire and Assessment (Adult)

General Information:

Client's Name: ____ Today's Date: ________________________

Address: ____

Phone: ____ Phone #2: ____

Email: ____ Preferred language: ________________________________

Age: _______________________ Date of Birth: _______________________ Gender: _____________________________

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

Occupation (what are you doing in life and how do you feel about it?): ____

____

How did you get referred to our office? ____

Emergency Contact: ____ Phone: ________________________________

Briefly explain your reason for seeing a Dietitian today: ____

____

____

____

Medical History:

Primary Care Provider: ____ Phone: ________________________

Address: ____

Height: ____' ____" Weight: _____ lbs.

List any other health care professionals you see on a regular basis (cardiologist, endocrinologist, therapist, etc.):

____

____

Indicate below if you have/had any of the following conditions: (Check all that apply)

_____ Allergies	_____ Heart disease	_____ Osteoporosis
_____ Cancer	_____ High blood pressure	_____ Anxiety, Depression, OCD, PTSD
_____ Diabetes	_____ High cholesterol	
_____ Eating disorder	_____ Kidney disease	_____ Thyroid disease
_____ Gastrointestinal Disease	_____ Obesity	_____ Other: _____________

List below the type and dosage of any medications, supplements, vitamins or herbs you are currently taking.

______________________________________ ____

______________________________________ ____

______________________________________ ____

Family History:

Please tell me about your family and family dynamics:

What was eating and food like in your house growing up? Was there concern about weight or dieting?

Does anyone in your family have a history of chronic illnesses (eating disorder, diabetes, heart disease, high cholesterol, high blood pressure, thyroid condition, PCOS)?

Eating / Lifestyle Habits:

Do you enjoy eating? ___ Yes ___ No Do you skip meals? ___ Yes ___ No

If yes, which ones do you skip and why?____

____

How many meals do you eat per day? _______ How many snacks do you eat per day? _________

Where do you eat your meals and snacks? ____

Who does the cooking/ food shopping? ____

How many meals per week do you eat from or at a restaurant? ___________

What restaurant or take out to you normally eat? ____

Do you enjoy fruits and vegetables? ____ Yes ____ No

Please list any foods you dislike: ____

____

List any food allergies/sensitivities you have as well as any foods you avoid for religious and/or personal reasons:

____

Do you eat and multitask (i.e. driving, working, computer, tv)? ___ Yes ___ No

Do you feel as if you are a fast, slow or an averaged paced eater? ___ Yes ___ No

Do you read nutrition labels? ___ Yes ___ No

If yes, what do you look for? ____

Do you smoke? ___ Yes ___ No

If yes, how many cigarettes/cigars per day? _____

Do you drink alcohol? ___ Yes ___ No

If yes, how often do you consume alcohol? (Circle the best answer)

Daily *A few times per week* *A few times per month*

If yes, about how many alcoholic drinks do you consume per week? _____

How many times a week do you consume soda or sweetened beverages (i.e., sports drinks, lemonade, iced tea etc.)?

____

Approximately how many ounces/cups of water do you drink a day? _____

Do you feel as if you overeat? ___ Yes ___ No

If yes, how often and why? ____

Are there any foods you feel "out of control" eating?____

Do you ever vomit after eating? ___ Yes ___ No

Do you feel as if you under eat? ___ Yes ___No

If yes, how often and why? ____

____

Do you experience any of the following if you have not eaten in a while? (Check any that apply)

___ Irritability ___ Lightheadedness ___ Weakness ___Headache ___Other: ___________

Have you tried to make changes to your diet in the past? ___ Yes ___ No

What obstacles have you faced, or might you face, when trying to improve your diet? (Check all that apply)

___ Emotional stress

___ Frequent travel

___ Lack of money to buy nutritious foods

___ Lack of time to prepare healthy meals

___ Work schedule/requirements

___ Lack of support from relatives/ friends/ coworkers

___ Other: ______________________________

___ None

Rate your energy level. (Circle the best answer)

Excellent *Good* *Fair* *Poor*

How would you rate your quality of sleep? (Circle the best answer)

Excellent *Good* *Fair* *Poor*

How many hours of sleep do you get per night? _____

Do you often wake up at night and eat? ___ Yes ___ No

How many days per week do you exercise? ________________

How long does each session last? ____

Describe what type of exercise you do. ____

Do you enjoy exercising? ____Yes ____ No ____ Sometimes

Weight Questionnaire:

(If this section feels uncomfortable, please leave blank and we can discuss together)

How do you feel about the way you look at this weight? (Circle one)

Extremely unhappy *Unhappy* *Neutral* *Happy* *Very happy*

At what age did weight gain start? ___________________

Highest Adult Weight? ______________ Age: ____________

Lowest Adult Weight? _______________ Age:_____________

Do you weight yourself and how often? ____

How often do you feel your weight affects your daily activities? (Circle one)

Always *Often* *Rarely* *Never*

What weight loss/fitness/lifestyle programs have you tried in the past? (Check all that apply)

____ Diet on your own ____ LA Weight Loss _____ Weight Watchers

____ Exercise at home ____ Jenny Craig _____ NutriSystem

____ Doctor run weight loss ____ Gym/Personal Trainer _____ Bariatric Surgery

____ RD or nutritionist Other: _______________________________________

Include below anything else you would feel is important.

____
____
____