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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				