

# *Nutrition Therapy Associates*

## Nutrition Assessment / Intake Form

Name: \_\_\_\_\_ Email: \_\_\_\_\_

Phone – Home: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

Address: \_\_\_\_\_

Age: \_\_\_\_\_ DOB: \_\_\_\_\_ Ht: \_\_\_\_\_ Wt: \_\_\_\_\_ Profession: \_\_\_\_\_

Referred by: \_\_\_\_\_ Reason for Referral: \_\_\_\_\_

Reason for appointment: \_\_\_\_\_

Have you ever worked with a Nutrition Therapist?  Yes  No If yes, who: \_\_\_\_\_

Please list names of any of the following professionals with whom you are working:

Therapist: \_\_\_\_\_ Physician: \_\_\_\_\_

Psychiatrist: \_\_\_\_\_ Trainer: \_\_\_\_\_

List medications you are currently taking: \_\_\_\_\_

List food and/or vitamin/mineral supplements you are taking: \_\_\_\_\_

### ***Medical History***

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

<b>Disease/Condition</b>	<b>Self</b>	<b>Family</b>	<b>Relationship</b>	<b>Treatment</b>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Cardiovascular Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Obesity	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Intestinal problems	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Menstrual problems	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Food Allergies	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Food Intolerances	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Mental Health Issues	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Drug Dependency	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Other	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

Are you currently being treated for any medical conditions:  Yes  No Specify: \_\_\_\_\_

Has your doctor recommended you follow a special diet? Yes No Specify: \_\_\_\_\_

Are you currently following this diet? Yes No If yes - indicate changes you are making; if not - please indicate why: \_\_\_\_\_

Do you chew gum? Yes No A lot Amount/day: \_\_\_\_\_

Do you drink alcohol? Yes No Number of drinks/wk: \_\_\_\_\_

Do you smoke cigarettes? Yes No Quit Amount/day: \_\_\_\_\_

Do you use drugs? Yes No Explain: \_\_\_\_\_

**Weight History**

Do you weigh yourself? Yes No How often? \_\_\_\_\_

What has been your highest weight ? \_\_\_\_\_ Age \_\_\_\_\_ Lowest weight ? \_\_\_\_\_ Age \_\_\_\_\_

What would like to weigh? \_\_\_\_\_ Last time you weighed this? \_\_\_\_\_ For how long? \_\_\_\_\_

"Set point" is a weight where the body tends to stabilize with normal eating. What do you think your "set point" weight is? \_\_\_\_\_ Last time you weighed this? \_\_\_\_\_ For how long? \_\_\_\_\_

How many calories do you think you need to maintain your current weight? \_\_\_\_\_

How many calories do you think you need to maintain your desired weight? \_\_\_\_\_

What is your family's attitude about health? \_\_\_\_\_

What is your family's attitude about health? \_\_\_\_\_

**Menstrual History**

Are you currently menstruating: Yes No Have never menstruated

Age began menstruating: \_\_\_\_\_ Approximate weight at that time: \_\_\_\_\_ Height: \_\_\_\_\_

Date last menstrual cycle: \_\_\_\_\_ Average weight fluctuation during menstrual cycle? \_\_\_\_\_

Are you taking birth control pills/estrogen pills? Yes No

Do you experience PMS? Yes No

As you lose weight, do your cycles become irregular or cease? Yes No At what weight? \_\_\_\_\_

**Eating Patterns**

Describe what hunger feels like to you: \_\_\_\_\_

Describe what fullness feels like to you: \_\_\_\_\_

How do you know when to quit eating ? \_\_\_\_\_

<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do you usually eat when you get hungry?			
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do you often eat when you are not hungry?			
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Can you tell the difference between physical hunger and "emotional hunger"?			
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do nutrition facts influence your decision of what to eat? Check all that apply: ___Calories ___Carb ___ Fat ___Vitamins ___ Minerals Other: _____			
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do you eat standing up?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do you eat faster than others?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do you eat in the car?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do you eat slower than others?

<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do you eat while watching TV?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do you eat when stressed?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do you eat while reading?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do you eat when bored?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do you eat while on the computer?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do you eat when anxious?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do you eat with others?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do you eat when lonely?

<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do you avoid certain foods? Please specify: _____ _____
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What are your favorite foods? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What food don't you like? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Circle any of the following that describes your eating patterns:

- |   |  |
|---|--|
| a) Eat 3 meals each day.                      | i) Binge followed by diuretics.          |
| b) Eat a 'normal' amount of food.             | j) Binge followed by exercise.           |
| c) Eat 3 meals with snacks.                   | k) Vomit without binging.                |
| d) Restrict intake of food.                   | l) Restrict food intake without binging. |
| e) Binge without purging.                     | m) Use laxatives without binging.        |
| f) Binge followed by vomiting.                | n) Use diuretics without binging.        |
| g) Binge followed by restricting food intake. | o) Exercise excessively without binging. |
| h) Binge followed by laxatives.               | p) Eat constantly throughout the day.    |

### ***Dieting History***

How many times have you tried to lose weight? \_\_\_\_\_

Age at first attempt: \_\_\_\_\_ years      Your height at that time? \_\_\_\_\_ Weight? \_\_\_\_\_

What did you do? \_\_\_\_\_

Why did you go on the diet? \_\_\_\_\_  
\_\_\_\_\_

### **Have you ever used any of the following to attempt to control your weight?**

Commercial diet programs	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Liquid diets	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Fad diets	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Prescription diet pills	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Over-the-counter diet pills	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Laxatives	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Diuretics	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Ipecac Syrup	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Vomiting	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Self Designed program	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____

Other	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
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Do you eat uncontrollably at times?  Yes  No If yes, how often? \_\_\_\_\_

At what age did this begin? \_\_\_\_\_ years

Is this followed by:

- Vomiting                      Ages: \_\_\_\_\_                      How often: \_\_\_\_\_
- Laxative use                      Ages: \_\_\_\_\_                      How often: \_\_\_\_\_ Amount: \_\_\_\_\_
- Excessive exercising                      Ages: \_\_\_\_\_                      How often: \_\_\_\_\_
- Self Harm                      Ages: \_\_\_\_\_                      How often: \_\_\_\_\_
- Negative Emotions                      Ages: \_\_\_\_\_                      How often: \_\_\_\_\_
- Other (explain) \_\_\_\_\_

Have you ever been diagnosed with an eating disorder?  Yes  No Please Explain: \_\_\_\_\_

Are you currently or have you ever received treatment? \_\_\_\_\_

Do you currently restrict food for weight control?  Yes  No

Please Explain: \_\_\_\_\_

Do you currently exercise for weight control?  Yes  No

Please Explain: \_\_\_\_\_

<b><i>Disordered Eating Behaviors</i></b>
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*Please check if you experience any of the following:*

<input type="checkbox"/>	Avoid eating a food if you do not know how it was prepared	<input type="checkbox"/>	Are scared to try new foods
<input type="checkbox"/>	Avoid eating a food if you do not know it's nutritional content	<input type="checkbox"/>	Won't eat in front of others
<input type="checkbox"/>	Won't eat unless you are able to exercise or purge afterward	<input type="checkbox"/>	Hide food so others will think you ate it
<input type="checkbox"/>	Become upset if you are unable to eat at a certain time	<input type="checkbox"/>	Hide food so you can binge
<input type="checkbox"/>	Become upset if you eat foods other than what you planned	<input type="checkbox"/>	Feel guilty after eating
<input type="checkbox"/>	Eat foods that are different from the rest of your family	<input type="checkbox"/>	Believe there are good foods / bad foods
<input type="checkbox"/>	Count calories	<input type="checkbox"/>	Feel ashamed of your eating
<input type="checkbox"/>	Count fat grams	<input type="checkbox"/>	Feel food is controlling your life
<input type="checkbox"/>	Count carbohydrate grams	<input type="checkbox"/>	
<input type="checkbox"/>	Count protein grams	<input type="checkbox"/>	
<input type="checkbox"/>	Count Weight Watchers points	<input type="checkbox"/>	
<input type="checkbox"/>	Cut your food into small pieces	<input type="checkbox"/>	
<input type="checkbox"/>	Weigh/ measure your food	<input type="checkbox"/>	
<input type="checkbox"/>	Refuse to eat after certain hour	<input type="checkbox"/>	
<input type="checkbox"/>	Eat the same foods daily	<input type="checkbox"/>	
<input type="checkbox"/>		<input type="checkbox"/>	

**Exercise History**

Are you currently exercising? Yes No Describe: \_\_\_\_\_

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22. Describe past history with exercise: \_\_\_\_\_

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23. Do you consider yourself a compulsive exerciser? Yes \_\_\_ No \_\_\_

Have you exercised in the past year? Yes No

Do you have any physical conditions that limit your ability/safety to exercise? Yes No

24. What are your goals for nutrition counseling? Please list and prioritize with #1 as most important.

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