

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:

Disease/Condition	Self	Family	Relationship	Treatment
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: _____ _____
------------------------------	-----------------------------	--

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	_____
-------	------------------------------	-----------------------------	-------

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: _____

<i>Disordered Eating Behaviors</i>

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: _____

22. Describe past history with exercise: _____

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.
