New Patient Nutrition Assessment Form

First Name _____ Last Name_____

Address _____

Please indicate your preferred method of contact: cell home email

Home Phone (_____)_____-_____ Birth Date _____/_____/_____

Cell Phone: (_____)_____-_____ Age _____

Occupation _____ Email : _____

Do you have children? Yes No Height: ___′ ____ ″ Weight: _____

Marital status: _____ Sex: _____

With whom do you live? (Include children, parents, relatives, and/or friends. Please include ages.)
Example: Sarah, daughter, age 7

_____

_____

Primary Care Provider _____

Date of last physical exam _____

Other doctors/specialists you see:

_____

GOALS AND READINESS ASSESSMENT

I would like to visit with the dietitian because…

_____
_____
_____

My food and nutrition-related goals are…

_____
_____
_____

My overall, health goals are…

_____
_____
_____

If I could change three things about my health and nutritional habits, they would be…

1. _____
   _____
2. _____
   _____
3. _____
   _____

The biggest challenge(s) to reaching my nutrition goals is/are:

_____
_____
_____

In the past, I have tried the following techniques, diets, behaviors, etc. to reach my nutrition goals…

_____
_____
_____

On a scale of 1 (not willing) to 5 (very willing), please indicate your readiness/willingness to do the following:

To improve your health, how ready/willing are you to…	**1**	**2**	**3**	**4**	**5**
Significantly modify your diet					
Take nutritional supplements each day					
Keep a record of everything you eat each day					
Modify your lifestyle (ex: work demands, sleep habits, physical activity)					
Practice relaxation techniques					
Engage in regular exercise/physical activity					
Have periodic lab tests to assess your progress					

PAST MEDICAL AND SURGICAL HISTORY

Please indicate whether you or your relatives* have been diagnosed with any of the following diseases or symptoms (specify which relative and the date of diagnosis). *Relatives include: parents, grandparents, siblings.

	Illness/Disease/Symptom	Self: Age Diagnosed	Relative: Age Diagnosed	Describe/Specify
☐	Allergies (please specify type of allergy)			
☐	Anemia			
☐	Anxiety or Panic Attacks			
☐	Arthritis (osteoarthritis or rheumatoid)			
☐	Asthma			
☐	Autoimmune condition (specify type)			
☐	Bronchitis			
☐	Cancer			
☐	COPD			
☐	Crohn's Disease or Ulcerative Colitis			
☐	Depression			
☐	Diabetes (Specify: Type I, II, Prediabetes, Gestational Diabetes)			
☐	Dry, itchy skin, rashes, dermatitis			
☐	Eczema			
☐	Emphysema			
☐	Epilepsy, convulsions, or seizures			
☐	Eye Disease (please specify)			
☐	Fibromyalgia			
☐	Food Allergies or Sensitivities			
☐	Fungal Infection (athlete's food, ringworm, other)			
☐	Gallbladder Disease/Gallstones (specify)			
☐	Gout			
☐	Heart attack/Angina			
☐	Heartburn			
☐	Heart disease (specify)			
☐	Hepatitis			
☐	High blood fats (cholesterol, triglycerides)			
☐	High blood pressure (hypertension)			
☐	Hypoglycemia (low blood sugar)			
☐	Intestinal Disease (specify)			
☐	Infammatory Bowel Disease (Crohn's or Ulcerative Colitis)			
☐	Irritable bowel syndrome			
☐	Kidney disease/failure or Kidney stones			
☐	Lung disease (specify)			
☐	Liver disease			
☐	Mononucleosis			
☐	Osteoporosis			
☐	PMS			
☐	Polycystic Ovarian Syndrome			

Illness/Disease/Symptom	Self: Age Diagnosed	Relative: Age Diagnosed	Describe/Specify
☐ Pneumonia			
☐ Prostate Problems			
☐ Psychiatric Conditions			
☐ Seizures or epilepsy			
☐ Sinusitis			
☐ Sleep apnea			
☐ Stroke			
☐ Thyroid disease (hypo- or hyperthyroid)			
☐ Urinary Tract Infection			
☐ Other (describe)			
Injuries	**Age**	**Describe/Specify**	
☐ Back injury			
☐ Broken (specify)			
☐ Head injury			
☐ Neck injury			
☐ Other (describe)			
Diagnostic Studies	**Age at study**	**Describe/Specify**	
☐ Barium Enema			
☐ Bone Scan			
☐ CAT Scan: Abdom., Brain, Spine (specify)			
☐ Chest X-ray			
☐ Colonoscopy or Sigmoidoscopy (specify)			
☐ EKG			
☐ Liver scan			
☐ NMR/MRI			
☐ Upper GI Series			
☐ Other (describe)			
Operations	**Age at operation**	**Describe/Specify**	
☐ Dental Surgery			
☐ Gall Bladder			
☐ Hernia			
☐ Hysterectomy			
☐ Tonsillectomy			
☐ Other (describe)			

Please complete the following information concerning your family's health history:

	If Living		If Deceased			If Living		If Deceased	
	Age	Health	Age at death	Cause		Age	Health	Age at death	Cause
Father					**Spouse/Partner**				
Mother					**Children**				
Siblings									

MEDICAL SYMPTOMS QUESTIONNAIRE

Check each of the following symptoms based upon your typical health profile for the past 30 days.

HEAD
_____Headaches
_____Faintness
_____Dizziness
_____Insomnia

EYES
_____ Watery or itchy eyes
_____ Swollen, reddened or sticky eyelids
_____ Bags or dark circles under eye
_____ Blurred or tunnel vision (does not include near or far-sightedness)

EARS
_____ Itchy ears
_____ Earaches, ear infections
_____ Drainage from ear
_____ Ringing in ears, hearing loss

NOSE
_____ Stuffy nose
_____ Sinus problems
_____ Hay fever
_____ Sneezing attacks
_____ Excessive mucus formation

MOUTH/ THROAT
_____ Chronic cough
_____ Gagging, frequent need to clear throat
_____ Sore throat, hoarseness, loss of voice
_____ Swollen or discolored tongue, gums, lips
_____ Canker sores

SKIN
_____ Acne
_____ Hives, rashes, dry skin
_____ Hair loss
_____ Flushing, hot flashes
_____ Excessive sweating

HEART
_____ Irregular or skipped heartbeat
_____ Rapid or pounding heartbeat
_____ Chest pain

LUNGS _____ Chest congestion
_____ Asthma, bronchitis
_____ Shortness of breath
_____ Difficulty breathing

DIGESTIVE TRACT
_____ Nausea, vomiting
_____ Diarrhea
_____ Constipation
_____ Bloated feeling
_____ Belching, passing gas
_____ Heartburn
_____ Intestinal/stomach pain

JOINT/MUSCLE
_____ Pain or aches in joints
_____ Arthritis
_____ Stiffness or limitation of movement
_____ Pain or aches in muscles
_____ Feeling of weakness or tiredness

WEIGHT
_____ Binge eating/drinking
_____ Craving certain foods
_____ Excessive weight
_____ Compulsive eating
_____ Water retention
_____ Underweight

ENERGY/ACTIVITY
_____ Fatigue, sluggishness
_____ Apathy, lethargy
_____ Hyperactivity
_____ Restlessness

MIND _____ Poor memory
_____ Confusion, poor comprehension
_____ Poor concentration
_____ Poor physical coordination
_____ Difficulty in making decisions
_____ Stuttering or stammering
_____ Slurred speech
_____ Learning disabilities

EMOTIONS
_____ Mood swings
_____ Anxiety, fear, nervousness
_____ Anger, irritability, aggressiveness
_____ Depression

OTHER _____ Frequent illness
_____ Frequent or urgent urination
_____ Genital itch or discharge

MEDICATION, SUPPLEMENT, AND ANTIBIOTIC INTAKE:

Please provide the names of medications, supplements, and/or antibiotics that you are currently taking.

Medication/Supplement/ Antibiotic	Dose	Units	Frequency	Start Date	Stop Date
Example: One-a-Day (brand) Men's Multivitamin	1200	Mg	Daily	08/12/2019	current

Are you allergic to any medications? Yes No Please list: _____

LIFESTYLE

Physical Activity: Using the table, please describe your physical activity.

Activity	Type/Intensity (low-moderate-high)	# Days/week	Length
Walking, jogging			
Strength training: weights, etc.			
Sports or other activity (specify)			
Yoga/stretching			

Does anything limit you from being physically active?

_____

Indicate daily stressors and rate the level of stress from 1 (extremely low) to 10 (extremely high):

Work_____ Family_____ Social_____ Financial_____ Health_____ Other_____

What helps you to relax?

_____

On average, how many hours of sleep do you get? Weekdays_____ Weekends_____

Do you smoke? ☐ **Never** ☐ **In the past** ☐ **Currently** **How long?**_____

Alcohol use ☐ **Never** ☐ **In the past** ☐ **Currently** **Type/amount/frequency**_____

Drug use ☐ **Never** ☐ **In the past** ☐ **Currently** ☐ **Prefer not to discuss** **Type/frequency**_____

WEIGHT HISTORY

Height _____ Current Weight _____ Desired Body Weight _____
Highest Adult Weight _____ When? _____ Weight 1 year ago _____

Have you had any recent changes in your weight that you are concerned about? If yes, please explain: ☐ Yes ☐ No

_____

DIGESTIVE HISTORY

- **Do you associate any digestive symptoms with eating certain foods?** ☐ **Yes** ☐ **No**
- Please explain:_____

  _____
- How often do you have a bowel movement? _____
- If you take laxatives, what type/brand and how often?

  _____

- Would you describe your stools are hard, soft, or loose? (circle one)
- Please indicate how often you experience the following symptoms:

Heartburn	Often	Sometimes	Rarely
Gas	Often	Sometimes	Rarely
Bloating	Often	Sometimes	Rarely
Stomach	Often	Sometimes	Rarely
Nausea/ Vomiting	Often	Sometimes	Rarely
Diarrhea	Often	Sometimes	Rarely
Constipation	Often	Sometimes	Rarely

DIET HISTORY

Do you follow any special diet or have diet restrictions or limitations for any reason (health, cultural, religious or other)? Yes No If so, please describe: _____

Please list any food allergies, sensitivities or intolerances

_____

Who prepares the most of your meals? _____ Who shops for food? _____

If you do, how much time do you spend cooking/preparing meals each day?

_____

INTAKE INFORMATION:

If you **currently** follow a special diet/nutritional program, check the following that apply:

☐Low Fat	☐Low Carb	☐High Protein	☐Low Sodium
☐No Gluten	☐Vegetarian	☐Vegan	☐Diabetic
☐No Dairy	☐No Wheat	☐Weight Loss	☐Other: _____

Which meals do you eat regularly, circle all that apply.

Breakfast Lunch Dinner Snacks

The nutrition/eating habits that are most challenging for me: _____

_____

_____

The nutrition/eating habits that I am most pleased with: _____

_____

_____

Beverage Intake: Please indicate the beverages you drink, and how often you drink them. Fill in the "Daily Amount", "Weekly Amount", and/or "Monthly Amount"

Beverage Type	Daily Amount	Weekly Amount	Monthly Amount
Example: Coffee: X reg ☐decaf ☐latte	2 – 8 oz cups	—	—
Water: ☐tap ☐filtered ☐bottled			
Coffee:☐reg. ☐decaf. ☐latte			
Tea: what type(s)?_____			
Juice: ☐Natural ☐Fruit drinks			
Soda: ☐regular ☐diet			
Milk: ☐whole ☐2% ☐1% ☐skim			
Milk alternative Type_____			
Alcohol: ☐wine ☐beer ☐liquor			
Other _____			

Eating style:

Food cravings

_____

Food dislikes

_____

Based on how you eat on a regular basis, please check all that apply:

☐Fast Eater
☐Erratic eater
☐Emotional eater (stressed, bored, sad, etc.)
☐Late night-eater
☐Time constraints
☐Dislike "healthy" food
☐Travel frequently
☐Do not plan meals/menus
☐Rely on convenience items
☐Family member(s) have different tastes
☐Love to eat
☐Eat too much
☐Eat because I have to
☐Negative relationship with food
☐Struggle with eating issues
☐Confused about food/nutrition
☐Frequently eat fast food
☐Poor snack choices

The food/nutrition questions that I would like to ask are:_____

_____

_____

_____

_____

_____

_____