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## CLIENT NUTRITION INFORMATION

Name:  
Address:  
Phone:  
E-mail Address:

Date:

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### Medical History

Diagnosis:

Treatment history

Surgery:

Additional Therapies:

Physicians Names:

*Please indicate if you would like to have information shared with your medical team*  
If so, you will need to complete a release at your first visit and provide the address of your physician/s.

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Other Nutrition/Health Concerns

1.

2.

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What would you like to learn during our session/s? What are your goals for nutrition therapy?

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Do you take any vitamin or herbal supplements? Please list the supplements and doses:

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Do you take any prescribed medications? Do you remember to take them? Any side effects?  
Please list the medications and doses to help identify any possible food/drug interactions:

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Have you read any books about nutrition and your condition? If so, which ones and how have they changed your diet?

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### Eating History

Nutrition Changes:

1. Have you ever changed your diet?  Yes  No
2. Why did you change?
3. When/What did you change?
4. Did you find the change helpful?

**Food Preferences:**

1. What foods do you like?
2. Please list any foods you no longer eat, and why (for example: meat, vegetarian)
3. Do you crave any foods?
4. Are you experiencing problems with nausea, vomiting, taste changes, or lack of appetite? If so, has it limited your ability to eat normal volumes of food and maintain your weight?
5. Are there any particular foods you have problems tolerating? (Foods that make you feel bad or cause abdominal pain, diarrhea, constipation, . . .)
6. Are you allergic to any foods? If so, please describe your symptoms

**Weight History**

	Weight	Age/Year
Highest weight as an adult		
Lowest weight over the past year		
Weight one month ago		
Weight 6 months ago		

**How tall are you?** \_\_\_\_\_

**Lifestyle Factors**

**Alcohol:** How many servings of alcohol do you have per week? \_\_\_\_\_

**Smoking:** Have you ever smoked?

**Sleep:** How many hours of sleep do you get per night? \_\_\_\_\_ Do you wake rested? Y N

**Exercise:**

If you are exercising, please list how much time, if any, you spend in each activity in a typical week?

- Light general exercise (cleaning, gardening): \_\_\_\_\_
- Light cardiovascular (walking): \_\_\_\_\_
- Intense cardiovascular (stairclimber, elliptical trainer, running): \_\_\_\_\_
- Sports \_\_\_\_\_ Dance Classes, etc \_\_\_\_\_
- Strength training (weights): \_\_\_\_\_
- Flexibility (stretching, yoga, Tai Chi): \_\_\_\_\_
- Other: \_\_\_\_\_

**Stress Level:** \_\_\_\_\_ (Rate on a scale of 0-10 with 0 being low and 10 being high)

What do you do to reduce stress?

**Energy Level:** \_\_\_\_\_ (Rate on a scale of 0-10 with 0 being low and 10 being high)

**Relaxation:**

What hobbies or activities do you enjoy on a regular basis?

How many hours per week do you spend in these activities? \_\_\_\_\_

**Social Factors**

How do your friends/family influence your eating patterns?

Who do you find supportive?

**Family History:**

- Please list any family history of heart disease \_\_\_\_\_, overweight \_\_\_\_\_, Cancer \_\_\_\_\_, High Blood Pressure \_\_\_\_\_, Osteoporosis \_\_\_\_\_, Diabetes \_\_\_\_\_, Other \_\_\_\_\_

**Eating Patterns:**

- How many meals do you eat out per week?
- Do you routinely skip meals?     Yes         No
- Is there any particular meal you have trouble with?  
Problem:

**Typical daily pattern:**

In trying to make small dietary changes in your current habits it is important to know what a typical day looks like for you. Here is an example of the information that can be helpful:

7:00 Wake, walk the dog 20 minutes  
 7:30 Breakfast at home: Coffee, 2 T cream, 1 Lenders Bagel, 1 T light cream cheese  
 8:00 Leave for work  
 10:00 Snack: Donut, 16 ounces Diet Coke  
 12:00 Lunch at work from Subway: 16 ounce Coke, 6 inch Sub with Turkey, mayonnaise, lettuce and tomato, small bag chips, etc, etc, etc.

**Use this space to record your daily pattern:**

**Please include other information that would be helpful for me to know:**