

Nutrition and Health History

Date of appointment:	_
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Patient's Name:		
Date of birth: Gend	Jer : ☐ Male ☐ Female	
Address:		
City:	State:	Zip code:
Home phone:	Cell phone:	
May we leave a message? ☐ Yes ☐	No Email:	
Marital status: ☐ Single ☐ Married	d	
Children: ☐ Yes ☐ No Ages:		
Occupation:		Hours worked per week:
Reason for visit:		
Have you ever seen a dietitian before?:	☐ Yes ☐ No Year / reason:	
Referring physician:		Phone:
Insurance:	Insurance ID:	
How did you hear about Nutriliciousby?	Z?	

PERSONAL DETAILS

WEIGHT HISTORY

Height: ft in Weight: lbs Briefly describe your weight history:			
What has been your highest weight as an adult?	At what age?		
What has been your lowest weight as an adult?	At what age?		
Weight goals: ☐ Lose ☐ Gain ☐ Maintain			
HEALTI	H HISTORY		
Current health status: ☐ Excellent ☐ Good ☐ Fair	Poor		
Current medical conditions (Please indicate year diagnosed and a	any medications or treatments)		
Year Condition Medication / Treatment	Year Condition	Medication / Treatment	
ADHD	Diabetes		
Allergies	Diarrhea	h	
Alzheimer's	Eczema		
Anorexia	Gluten Intolerance		
Anxiety	High blood pressure		
Bulimia Nervosa	High cholesterol		
Cancer	Irritable bowel syndrome		
Celiac Disease	Kidney Disease	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
Heart Disease	Liver Disease		
Cohn's Disease	Ulcerative Colitis		
Constipation	Other		
Depression	Other		
Other prescription medications:			
Nutritional supplements / vitamins / herbs:			
Women only: □ Pregnant □ Breast feeding □ Pos	t-menopausal		
Food allergies:			

NUTRITION HISTORY

Diet preference	es / Restriction	ns:				
☐ Vegan	□V	egetarian/	☐ Kosher	☐ No Whe	eat \Box	l No Lactose
☐ No Gluten		lo Dairy	□ N/a	☐ Other:		
How would you	describe your	diet right now?				
□ I feel I eat a	an overall heal	thy diet most days.				
☐ My diet nee	eds some impr	ovement, but overal	l I feel it is not	too bad.		
☐ I think my c	diet is probably	y missing a lot of wh	at my body ne	eds.		
☐ I don't reall	ly know if my c	diet is healthy or not	•			
Number of mea	ls / day:	Snacks			_	
How many mea	ls are prepare	d by you / family me	ember?	How many me	als do you eat o	ut per week?
Difficulty chew	ring: 🗆 Yes	□ No Diffice	ulty Swallowin	ng: 🗆 Yes 🗆 No)	
Do you use artif	ficial sweeten	ers? 🗆 Yes 🗆 N	No List na	me / brand:		
Water intake:	8	oz glasses/day				
Caffeine:	Coffee	□ Tea	☐ Carbonate	d drinks	times pe	r day / week / month
Tobacco:	Cigarettes	☐ Cigars	☐ Smokeless	Tobacco	times pe	r day / week / month
Alcohol:	Beer	□ Wine	☐ Liquor	-	times pe	r day / week / month
What method h	ave you tried i	in past to achieve yo	our weight/hea	alth goals? (Check all t	hat apply)	
☐ Low-calorie	e diets	☐ Low-fat diets	☐ Low	-carb diet	☐ Fasting	
☐ Meal Repla	cements	☐ Weight loss pills	☐ Exe	rcise	☐ Weight wat	chers
☐ The zone di	iet	☐ Bariatric surgery	☐ Low	Glycemic index diet	Other	
		LIFESTYLI	E & READINE	SS TO CHANGE		
Exercise / week				Type of exercise:		
Stress level:	□ Low □ M	loderate				
Readiness to adopt good nutrition and dietary habits: High Fair Not ready						
What other information would you like your dietitian to know?						

24 HOUR DIET RECALL

Meal	ltem	Amount	
Breakfast			
Lunch			
Dinner			
Snack 1			
Snack 2			
Beverages			
I acknowledge that the health information stated above is the best according to my knowledge.			
Signature of patient / guardian			
D /			