NutriliciousbyZ

Nutrition and Health History

Date of appointment: _____

PERSONAL DETAILS

Patient's Name: _____

Date of birth: _____ **Gender**: ☐ Male ☐ Female

Address: _____

City: _____ **State:** _____ **Zip code:** _____

Home phone: _____ **Cell phone:** _____

May we leave a message? ☐ Yes ☐ No **Email:** _____

Marital status: ☐ Single ☐ Married

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 NutriliciousbyZ? _____

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

HEALTH HISTORY

Current health status: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Current medical conditions (Please indicate year diagnosed and any medications or treatments)

Year	Condition	Medication / Treatment
	ADHD	
	Allergies	
	Alzheimer's	
	Anorexia	
	Anxiety	
	Bulimia Nervosa	
	Cancer	
	Celiac Disease	
	Heart Disease	
	Cohn's Disease	
	Constipation	
	Depression	

Year	Condition	Medication / Treatment
	Diabetes	
	Diarrhea	
	Eczema	
	Gluten Intolerance	
	High blood pressure	
	High cholesterol	
	Irritable bowel syndrome	
	Kidney Disease	
	Liver Disease	
	Ulcerative Colitis	
	Other	
	Other	

Other prescription medications: _____

Nutritional supplements / vitamins / herbs: _____

Women only: ☐ Pregnant ☐ Breast feeding ☐ Post-menopausal

Food allergies: _____

NUTRITION HISTORY

Diet preferences / Restrictions:

☐ Vegan ☐ Vegetarian ☐ Kosher ☐ No Wheat ☐ No Lactose

☐ No Gluten ☐ No Dairy ☐ N/a ☐ Other: _____

How would you describe your diet right now?

☐ I feel I eat an overall healthy diet most days.

☐ My diet needs some improvement, but overall I feel it is not too bad.

☐ I think my diet is probably missing a lot of what my body needs.

☐ I don't really know if my diet is healthy or not.

Number of meals / day: _____ **Snacks** _____ _____

How many meals are prepared by you / family member? _____ **How many meals do you eat out per week?** _____

Difficulty chewing: ☐ Yes ☐ No **Difficulty Swallowing:** ☐ Yes ☐ No

Do you use artificial sweeteners? ☐ Yes ☐ No **List name / brand**:

Water intake: _____ 8 oz glasses/day

Caffeine: ☐ Coffee ☐ Tea ☐ Carbonated drinks _____ times per day / week / month

Tobacco: ☐ Cigarettes ☐ Cigars ☐ Smokeless Tobacco _____ times per day / week / month

Alcohol: ☐ Beer ☐ Wine ☐ Liquor _____ times per day / week / month

What method have you tried in past to achieve your weight/health goals? (Check all that apply)

☐ Low-calorie diets ☐ Low-fat diets ☐ Low-carb diet ☐ Fasting

☐ Meal Replacements ☐ Weight loss pills ☐ Exercise ☐ Weight watchers

☐ The zone diet ☐ Bariatric surgery ☐ Low Glycemic index diet ☐ Other

LIFESTYLE & READINESS TO CHANGE

Exercise / week: _____ **Type of exercise:** _____

Stress level: ☐ Low ☐ Moderate ☐ High

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	Item	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 _____

Date: _____