

Women's Wellness Center

Nutritional Counseling Intake Form

General Information:

Name: _____ Date: _____

Age: _____ Date of Birth: _____ Gender: _____

Reason for Appointment: _____

Employment Status: Full Time Part Time Not Employed

Occupation: _____

Place of Employment: _____

Education level: Grammar School High School College Graduate School

Current School: _____ Grade: _____

Marital Status: Single Married Divorced Separated Widowed

Parent's Marital Status: Single Married Divorced Separated Widowed

Parent's Occupation(s): _____

Sibling(s): Brother(s): _____ Sister(s): _____

Number of Children: _____

Medical History:

Height: _____ Weight: _____ Weight 1 year ago: _____

Usual Weight: _____ Lowest Weight: _____ Highest Weight: _____

Desired Weight: _____

Have you lost or gained weight recently? Yes No

Was this an intentional change? Yes No

Do you weigh yourself? Yes No How Often? _____

Are you concerned with your weight? Yes No

(For Children)

Birth Weight: _____ Breast fed? Yes No How long? _____

Mother's Height: _____ Father's Height: _____

Please indicate whether you or a family member have/had any of the following conditions:

Disease/Condition	Self	Family	Relationship	Treatment
Asthma	_____	_____	_____	_____
Cancer	_____	_____	_____	_____
Cardiovascular Disease	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____

Drug Dependency _____
 Eating Disorder _____
 Food Allergies _____
 Food Intolerances _____
 Kidney Disease _____
 Headaches _____
 Heart Attack _____
 High Cholesterol _____
 Hypertension _____
 Intestinal Problems _____
 Menstrual Problems _____
 Mental Health Issues _____
 Obesity _____
 Osteoporosis _____
 Other _____

Are you currently being treated for any medical conditions? Yes No
 If yes, please specify: _____

Are you taking any medications? Yes No
 Please list: _____

Are you taking any vitamin, mineral, food or herbal supplements? Yes No
 Please list: _____

Have you ever been advised by your physician to follow a special diet? Yes No
 What type? _____

Are you currently following that diet? Yes No
 If not, indicate why; If yes, what changes have you made? _____

Do you drink alcohol? Yes No Number of drinks per week: _____
 Do you smoke cigarettes? Yes No Amount per day: _____
 How long have you smoked? _____ If you quit smoking, when? _____
 Do you use drugs? Yes No Please explain: _____

Dieting History:

How many times have you tried to lose weight? _____
 Age of first attempt: _____ Your weight at that time: _____
 What diet did you follow? _____
 Why did you go on that diet? _____

List other weight loss attempts:

Diet	Year	Outcome
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you experience periods during which you eat uncontrollably? Yes No

If yes, how often? _____

At what age did this begin? _____

Have you ever been diagnosed with an eating disorder? Yes No

Please explain: _____

Are you currently or have you ever received treatment? Yes No

If yes, please explain: _____

Do you currently restrict food for weight control? Yes No

Please explain: _____

Do you currently exercise for weight control? Yes No

Please explain: _____

Exercise History:

Do you exercise? Yes No

List type, duration, frequency, and intensity of exercise activities: _____

Have you exercised in the past year? Yes No

List type, duration, frequency, and intensity of exercise activities: _____

Do you have any physical conditions that limit your ability to exercise? Yes No

Please specify: _____

Family Weight History:

Are any members of your family overweight? Yes No

Explain: _____

Are any members of your family underweight? Yes No

Explain: _____

Does anyone in your family diet? Yes No

Explain: _____

Did/Does anyone in your family have an eating disorder? Yes No

Explain: _____

Do you eat together? Yes No

What meals? _____

Eating Patterns:

How many days per week do you eat:

Breakfast: _____ Lunch: _____

Dinner: _____

Do you snack? _____ Yes _____ No

When? _____

Do you buy or pack your lunches?

_____ Buy # days per week: _____

_____ Pack # days per week: _____

Do you eat out? _____ Yes _____ No

How many meals per week? _____

What restaurants do you usually choose?

- | | | |
|----------|----------|----------|
| 1. _____ | 4. _____ | 7. _____ |
| 2. _____ | 5. _____ | 8. _____ |
| 3. _____ | 6. _____ | 9. _____ |

Who usually prepares the food at home? _____

Do you know how to cook? _____ Yes _____ No

Who does the grocery shopping? _____

Do you read food labels? _____ Yes _____ No What do you look at on the label? _____

Do the nutrition facts influence your decision to eat the food? _____ Yes _____ No

Do you eat standing up? _____ Yes _____ No

Do you eat in the car? _____ Yes _____ No

Do you eat while watching TV? _____ Yes _____ No

Do you eat while reading or on the computer? _____ Yes _____ No

Do you eat with others? _____ Yes _____ No

Do you eat fast? _____ Yes _____ No

Do you eat when bored? _____ Yes _____ No

Do you eat when stressed? _____ Yes _____ No

Do you eat when you are anxious? _____ Yes _____ No

Do you eat when you are lonely? _____ Yes _____ No

Do you eat when you are hungry? _____ Yes _____ No

Do you eat when you are not hungry? _____ Yes _____ No

Do you avoid certain foods? _____ Yes _____ No

Please specify: _____

What are your favorite foods? _____

Goals/Expectations

Do you want to change your eating habits? _____ Yes _____ No

Why? _____

Did you have any expectations from coming to see the nutritionist today? _____ Yes _____ No

Please explain:

Food Frequency Checklist

Patient's Name: _____ Date: _____

Check the Frequency the Following Foods are Consumed	Never or Less than Once per Week	1-2 Times per Week	3-7 Times per Week	More than Once a Day
Lean Beef				
High Fat Beef				
Sausage, Bacon, Lunchmeat				
Pork				
Poultry				
Poultry – Prebreaded, e.g. nuggets				
Poultry – Fried				
Fish				
Fish – Prebreaded, e.g. fish sticks				
Fish – Fried				
Shellfish				
Beans				
Peanut Butter				
Pizza				
Milk (Specify Type)				
Cream				
Cheese				
Cheese – Regular				
Cheese – Low Fat				
Cheese – Non-Fat				
Yogurt				
Ice Cream				
Frozen Yogurt				
Eggs				
Oils				
Butter				
Margarine				
Vegetables				
Fruits				
Fruit Juice				
Breads				
Cereals				
Pasta, Noodles, Rice, Etc. (cup)				
Potatoes				
Commercial Baked Goods (cookies, donuts, cakes, etc.) (Serving)				

Check the Frequency the Following Foods are Consumed	Never or Less than Once per Week	1-2 Times per Week	3-7 Times per Week	More than Once a Day
Cookies – Regular				
Cookies – Low Fat				
Cookies – Fat Free				
Soft Drinks (Non-Diet) (Serving)				
Snack Crackers (Serving)				
Nuts and Seeds (1/4 Cup)				
Potato Chips or Corn Chips (Cup)				
Sherbets and Ices (1/2 Cup)				
Candy				
Frozen Meals				
Chinese Food				
Fast Food				