

Personal Contact Information

Name:

Address:

Home
phone:

Work
phone:

Occupation:

Cell phone:

Email
address:

Date of
birth:

Current age:

Emergency contact:

Phone number:

Would you like to be added to my mailing list to receive a calendar of upcoming events?

Yes No

If yes, via email or regular mail

Referral Source:

Seen dietitian before? yes no If yes, what for:

Physician Name:

Date of your last physical examination:

Name: _____ Date: _____

Ht: _____ Current Wt: _____

Weight history:

Highest weight and when? _____

Lowest weight and when? _____

During the past 6 months my weight has:

- ___ decreased by 10 lbs or more
- ___ decreased 5-9 pounds
- ___ remained relatively stable
- ___ increased by 5-9 pounds
- ___ increased by 10 pounds or more

How often do you weigh yourself? _____

How many minutes of physical activity do you average each week? _____ minutes per week

What do you do for physical activity?

How many hours do you typically spend each day in front of the TV? _____ hours

How many hour do you typically spend each day sitting at a computer or playing video games?
_____ hours

Do you eat regular meals? Yes No

Do you eat breakfast every day? Yes No

Do you eat your meals in front of the TV? Yes No If yes, how often?

Who does the food shopping in your home?

Who prepares the food in your home?

Do you have problems with:

___ diarrhea ___ constipation ___ nausea ___ bloated
___ headaches ___ sleep ___ dizziness
___ other: _____

Do you engage in the following and if so, frequency:

___ vomiting _____
___ laxatives _____
___ diuretic use _____
___ other drug use _____
___ binge eating _____
___ purging _____

Medical Assessment

- Yes No Has your doctor ever said you have heart trouble? If yes, explain:
- Yes No Do you frequently have pains in your heart and chest? If yes, explain:
- Yes No Do you often feel faint or have spells of severe dizziness? If yes, explain:
- Yes No Has a doctor ever told you your blood pressure was too high? If yes, explain:
- Yes No Has your doctor ever told you that you have a bone or joint problem, such as arthritis that has been aggravated by exercise, or might be made worse with increased physical activity? If yes, explain:
- Yes No Is there a good reason, not mentioned here, why you should not engage in physical activity even if you wanted to? If yes, explain:
- Yes No Have you ever had cancer? If yes, explain:
- Yes No Have you ever had diabetes? If yes, explain:
- Yes No Do you have kidney or gallstones? If yes, explain:
- Yes No Are you currently pregnant or have you had a baby within the last year?
If yes, due date: _____ or your baby's birth date: _____
- Yes No Have you ever had anorexia, bulimia, or other eating disorders? If yes, explain:
- Yes No Do you have any other physician diagnosed health problems? If yes, explain:
- Yes No Have you ever had surgery? If yes, explain:
- Yes No Have you ever been treated for depression or any other psychological problem? If yes, explain:
- Yes No Do you have anemia? If yes, explain:
- Yes No Are you hypoglycemic? If yes, explain:
- Yes No Do you have any allergies? If yes, explain:
- Yes No Have you ever had any health problems as a result of dieting? If yes, explain:
- Yes No Do you consider yourself to be in good health? If no, explain:
- Yes No Do you smoke? If yes, how much:
- Yes No Do you drink alcohol? If yes, how much and how often:
- Yes No Do you take vitamins and/or supplements? If yes, what kind and how much:
- Yes No Are you currently taking any prescription or nonprescription medications? If yes, explain:

Food intake:

Amount of the following fluids (in 8 oz cups) you typically consume a day.

___ skim milk ___ fruit juice ___ hard liquor ___ water ___ Seltzer water
___ low-fat milk ___ sugared soda ___ beer ___ coffee drinks ___ fruit/sport "drinks"
___ whole/2% milk ___ diet soda ___ wine ___ coffee ___ other _____

Meals eaten in a fast food restaurant (includes drive through and convenience stores):

Breakfast: ___ meals per week

Lunch: ___ meals per week

Dinner: ___ meals per week

Meals eaten in a traditional restaurant, cafeteria, coffee shop, or similar place:

Breakfast: ___ meals per week

Lunch: ___ meals per week

Dinner: ___ meals per week

Alcohol use:

___ none

___ glasses of wine per week

___ bottles of beer per week

___ mixed drinks or liqueurs per week

What type of food plan/eating pattern has worked for you before?

What are your top five favorite foods?

Client Acknowledgment

I, _____, the undersigned have completed and reviewed the assessment information described above and to the best of my knowledge believe this information to be true and accurate.

Client signature

Date: _____



Name: _____ **Date** _____

Address: _____

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

Home Phone: _____ **Work Phone:** _____

Email address: _____ **Date of Birth:** _____

How did you hear about our services? _____

May we thank the person who referred you? _____

For Office Use Only:

Therapist: _____ **Group:** _____ **WP:** _____