One's health and well-being are influenced by many different things, including lifestyle, family history, emotional health, and nutrition/eating habits. Please complete the following questionnaire to the best of your ability and give me an overall view of your general lifestyle and health habits.

New Patient Nutrition Assessment Form

Today's Date _____

Name _____

Age_____Sex_____ Marital Status _____ Where do you spend your time during the day? home, office, collab space, etc _____

Are you pregnant ? _____Yes _____No Due Date _____

With whom do you live (include children, parents, relatives and/or friends. Please include ages. (Example: Sarah, age 7 step daughter) _____

_____

_____

Goals and Readiness Assessment

I would like to visit with the dietitian today because:_____

_____

_____

My food and nutrition goals are:

_____

_____

_____

My overall health goals are: _____

_____

_____

If I could change 3 things about my health and nutritional habits, they would be …

1. _____
   _____
2. _____
   _____
3. _____
   _____

The biggest challenge (s) to reaching my nutrition goals is/are: _____

_____

_____

In the past, I have tried the following techniques, diets, behaviors, etc. to reach my nutrition goals

_____

_____

_____

On a scale of 1 (not willing) to 5 (very willing) please indicate your readiness/willingness to do the following:

To improve your health, how ready/willing are you to…	**1**	**2**	**3**	**4**	**5**
Significantly modify your diet					
Take nutritional supplements each day					
Keep a record of everything you eat each day					
Modify your lifestyle (ex: work demands, sleep habits, physical activity					
Practice relaxation techniques					
Engage in regular exercise/physical activity					
Have periodic lab tests to assess your progress					

7. Please complete the following information concerning your family's health history

	If Living		**If deceased**		**If living**			**If deceased**	
	age	**health**	**age at death**	**cause**		**age**	**health**	**age at death**	**cause**
Father					**spouse/ partner**				
Mother									
Siblings									

Medication, Supplement, and Antibiotic Intake:

Please provide the names of medications, supplement and /or antibiotics that you are currently taking:

Medication /Supplement/Antibiotic	**Dose**	**Units**	**Frequency**	**Start Date**	**Stop Date**
Example: One-a-Day (brand) Men's Multivitamin	1200`	mg	Daily	8/12/2010	current

Medication /Supplement/Antibiotic	Dose	Units	Frequency	Start Date	Stop Date

Medical Symptoms & History Questionnaire

Medical problem	Diagnosis date

Rate each of the following symptoms based upon your typical health profile for the past 30 days. If you have been having recent or somewhat severe health symptoms, please indicate that you will fill the questionnaire for the past 48 hours. ____Past 30 days _____Past 48 hours

Point Scale

0 - Never or almost never have the symptom
1 - Occasionally have it, effect is *not* severe
2 - Occasionally have it, effect is severe
3 - Frequently have it, effect is not severe
4 - Frequently have it, effect is severe

HEAD
_____Headaches
_____Faintness
_____Dizziness
_____Insomnia
Total_____

EYES
_____Watery or itchy eyes
_____Swollen, reddened or sticky eyelids
_____Bags or dark circles under eye
_____Blurred or tunnel vision
(does not include near or far-sightedness) **Total**_____

EARS
_____ itchy ears
_____ earaches, ear infections
_____ drainage from ear
_____ ringing in ears, hearing loss **Total**_____

NOSE
_____ stuffy nose
_____ sinus problems
_____ hay fever
_____ sneezing attacks
_____ excessive mucus formation **Total**_____

MOUTH/THROAT
_____ chronic cough
_____ gagging, frequent need to clear throat
_____ sore throat, hoarseness, loss of voice
_____ swollen or discolored tongue, gums, lips
_____ canker sores **Total**_____

SKIN

_____ acne
_____ hives, rashes, dry skin
_____ hair loss
_____ Flushing, hot flashes
_____ Excessive sweating **Total**_____

HEART

_____ Irregular or skipped heart beat
_____ Rapid or pounding heart beat
_____ Chest pain **Total**_____

LUNGS

_____ Chest congestion
_____ Asthma, bronchitis
_____ Shortness of breath
_____ Difficulty breathing **Total**_____

DIGESTIVE TRACT

_____ Nausea, vomiting
_____ Diarrhea
_____ Constipation
_____ Bloated feeling
_____ Belching, passing gas
_____ Heartburn
_____ Intestinal/stomach pain **Total**_____

JOINT /MUSCLE

_____ Pain or aches in joints
_____ Arthritis
_____ Stiffness or limitation of movement
_____ Pain or aches in muscles
_____ Feeling of weakness or tiredness **Total**_____

WEIGHT

_____ Binge eating/drinking
_____ Craving certain foods
_____ Excessive weight
_____ Compulsive eating
_____ Water retention
_____ Underweight **Total**_____

ENERGY/ACTIVITY

_____ Fatigue/sluggishness
_____ Apathy/lethargy
_____ Hyperactivity
_____ Restlessness **Total**_____

MIND

_____ Poor memory
_____ Confusion, poor concentration
_____ Poor physical coordination
_____ Difficulty making decisions
_____ Stuttering or stammering
_____ Slurred speech
_____ Learning disabilities **Total**_____

EMOTIONS

_____ Mood swings
_____ Anxiety, fear, nervousness
_____ Anger, irritability, aggressiveness
_____ depression **Total**_____

OTHER

_____ Frequent illness
_____ Frequent or urgent urination
_____ genital itch or discharge **Total**_____

LIFESTYLE

Physical Activity: Using the table, please describe your physical activity

Activity	Type/Intensity (Low- moderate-high)	#days per week	Duration (minutes)
Stretching/yoga			
Cardio/Aerobics (walking, jogging, biking, etc.)			
Strength Training (weight lifting, pilates, some yoga)			
Sports or Leisure (i.e. golf, tennis etc.)			
Other (specify/describe)			

Does anything limit you from being physically active?_____

Indicate daily stressors and rate the level of stress from 1 (extremely low) to 10 (extremely high):

Work _____Family _____ Social _____ Financial _____ Health_____ Other_____

Please explain_____

What helps you to unwind? _____

On average, how many hours of sleep do you get? Weekdays _____ Weekends_____

Do you smoke? Never _____ In the past _____ Currently _____ Low Long? _____

Alcohol Use: Never _____ In the past _____ Currently _____Type/ amount/frequency _____

_____

Drug Use Never _____ In the past _____ Currently _____ Prefer not to discuss _____

Type/ amount/frequency _____

WEIGHT HISTORY

Would you like to be weighed today Yes _____ No_____ If no, please be sure to tell me.

Height _____ Current Weight _____ Desired body Weight _____

Highest adult weight _____When _____ Weight one year ago_____

Have you had any recent changes in your weight that you are concerned about? Yes_____ No _____

If yes, please explain

_____

_____

DIGESTIVE HISTORY

- Do you associate any digestive symptoms with eating certain foods? Yes _____ No_____
- Please explain

_____
_____

- How often do you have a bowel movement? _____
- If you take laxative, what type/brand and how often?

_____

DIET HISTORY

If you follow a special diet/ nutritional program, check the following that apply:

_____ Low Fat	_____Low Carb	_____High Protein	_____Low Sodium
_____ No Gluten	_____Vegetarian	_____Vegan	_____Diabetic
_____ No Dairy	_____No Wheat	_____ Weight Loss	

_____Other: Please describe _____

What meals do you eat regularly, check all that apply?

_____Breakfast _____ Lunch _____Dinner/ Supper _____ Snacks (Times _____, _____, _____)

The nutrition/ eating habits that are most challenges for me are:

_____
_____
_____

The Nutrition / eating habits that I am most pleased with are :

_____
_____

Food cravings

_____

Food dislikes

_____

Eating Style: Based on how you eat on a regular basis, please check all that apply:

- ☐ Fast Eater
- ☐Erratic eater
- ☐Emotional eater (stressed, bored, sad, etc.)
- ☐late night - eater
- ☐Time constraints
- ☐Dislike healthy food
- ☐travel frequently
- ☐Do not plan meals/ menus
- ☐Rely on convenience items
- ☐Family member(s) have different tastes
- ☐Love to eat
- ☐Eat too much
- ☐Eat because I have to
- ☐Negative relationship with food
- ☐Struggle with eating issues
- ☐Confused about food/nutrition issues
- ☐Frequently eat fast food
- ☐Poor snack choices

Beverage Intake: Please indicate the beverages you drink, and how often you drink them. I Fill in the “Daily Amount”, “Weekly Amount”, and or “Monthly Amount”.

Beverage Type	Daily Amount	Weekly Amount	Monthly Amount
Example: **Coffee: ___regular___decaf___latte**	Ex. 2 - 8 ounce cups reg. coffee		
Water: ____tap___filtered___bottled			
Coffee: ___regular___decaf___latte			
Tea: what type(s)_____			
Juice: ___natural ____Fruit drink			
Soda: ____regular _____diet			
Milk: ____whole ____2% ___1%___Skim			
Milk Alternative: Type_____			
Alcohol: ___Wine____ Beer ____ Liquor			
Other _____			

How many meals per week do you eat out? What are the restaurants you go to frequently?

7 am – 11 am _____Restaurant_____

11 am – 4 pm _____Restaurant_____

4pm – 10 pm _____Restaurant_____

How much time each day do you spend on watching TV _____

The food/nutrition questions that I would like to ask are:

_____

_____

_____

Is there anything else you would like me to know?

_____

_____

_____

_____

Thank you!