

*Contact Information*

Client Name: \_\_\_\_\_ Date: \_\_\_\_\_

Gender: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_

Email Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone Number: \_\_\_\_\_

*Nutrition Intake*

What diet and nutrition topics do you want to address? \_\_\_\_\_

---

Which of the following describes your concerns? *Check all that apply*

Eating Habits       Health       Meal Planning       Weight       Physical Shape

Other \_\_\_\_\_

What is your goal for this office visit? \_\_\_\_\_

---

Have you seen a nutritionist or dietician before?  Yes  No

*If yes, was it helpful?*  Yes  No *Why?* \_\_\_\_\_

Describe any special dietary program or diet that you were on in the past ten years: \_\_\_\_\_

---

How many meals do you eat per day? \_\_\_\_\_

How many snacks do you have per day? \_\_\_\_\_

How would you identify your current diet? • Atkins • Ketogenic • Paleo • Normal • Vegan  
• Vegetarian  Gluten Free  Dairy Free  Other: \_\_\_\_\_

Do you have any special dietary requirements?  Yes  No

*If yes, please describe:* \_\_\_\_\_

How much plain water do you usually drink per day? \_\_\_\_\_

In the past, did you gain or lose a significant amount of weight?  Yes  No

*If yes, how much?* \_\_\_\_\_

Do you wear dentures?  Yes  No

Do you have any dental health problems?  Yes  No *If yes, please explain:* \_\_\_\_\_

Can you chew and swallow food or drink easily?  Yes  No *If no, please explain:* \_\_\_\_\_

Do you feel that your appetite is sufficient?  Yes  No *If no, please explain:* \_\_\_\_\_

Do you count calories?  Yes  No *If yes, how many calories do you consume each day?* \_\_\_\_\_

Do you weight yourself?  Yes  No *If yes, how often?*  Frequently  Occasionally

*What do you think is your ideal weight?* \_\_\_\_\_

Do you use laxatives?  Yes  No *If yes, what brand and dosage?* \_\_\_\_\_

Do you have any of the following feeling while you eat? *Please check all that apply*

Anxious  Bored  Comforted  Lonely  Sad  Prefer not to answer  Does not apply

How often do you have a bowel movement? \_\_\_\_\_

**Do you strain to have a bowel movement?**  Yes  No

**Do you have loose bowel movements?**  Frequently  Never  Occasionally

**What foods do you crave?** \_\_\_\_\_  
\_\_\_\_\_

**How often do you crave these foods?**  Frequently  Never  Occasionally

**What food(s) do you avoid eating (if any) because it gives you symptoms?** \_\_\_\_\_  
\_\_\_\_\_

**How often do you have indigestion?**  Frequently  Never  Occasionally

**Do you use any antacids?**  Yes  No *If yes, what brand and how often?* \_\_\_\_\_

### *Food Selection*

**Who does most of the meal selection (shopping) in your household?** \_\_\_\_\_

**Do you read nutrition labels?**  Frequently  Never  Occasionally

*If yes, what do you look for?* \_\_\_\_\_

**Do you buy low- sodium products?**  Frequently  Never  Occasionally

*What low-sodium products do you typically buy?* \_\_\_\_\_  
\_\_\_\_\_

**Do you buy low-fat products?**  Frequently  Never  Occasionally

*What low-fat products do you typically buy?* \_\_\_\_\_  
\_\_\_\_\_

**Do you buy sugar-free products?**  Frequently  Never  Occasionally

*What sugar-free products do you typically buy?* \_\_\_\_\_  
\_\_\_\_\_

**How often do you buy packaged meals?**  Frequently  Never  Occasionally

*What packaged meal products do you typically buy?* \_\_\_\_\_  
\_\_\_\_\_

**How often do you buy fresh meat or fish?**  Frequently  Never  Occasionally

What meat or fish do you typically buy? \_\_\_\_\_

How often do you buy grass fed, natural or organic meat?  Frequently  Never  Occasionally

**How often do you buy fresh produce?**  Frequently  Never  Occasionally

What fruits do you typically buy? \_\_\_\_\_

What vegetables do you typically buy? \_\_\_\_\_

How often do you buy organic produce?  Frequently  Never  Occasionally

**How often do you buy dairy products?**  Frequently  Never  Occasionally

What dairy products do you typically buy? \_\_\_\_\_

How often do you buy organic dairy products?  Frequently  Never  Occasionally

How often do you buy pasture-raised or omega-3 eggs?  Frequently  Never  Occasionally

### Meal Preparation

**Who does most of the meal preparation in your household?** \_\_\_\_\_

**Do you use a meal planning or preparation service?**  Yes  No

If yes, which service? \_\_\_\_\_

How often?  Frequently  Never  Occasionally

**How often do you prepare meals for yourself?**  Frequently  Never  Occasionally

# per day \_\_\_\_\_ # per week \_\_\_\_\_

**How often do you prepare meals for others?**  Frequently  Never  Occasionally

# per day \_\_\_\_\_ # per week \_\_\_\_\_

**What oils are you most likely to use?**  Olive  Canola  Safflower  Vegetable

Other: \_\_\_\_\_

**How often do you use real butter?**  Frequently  Never  Occasionally

**How often do you use margarine?**  Frequently  Never  Occasionally

**How often do you use lard?**  Frequently  Never  Occasionally

**How do you prefer to prepare your meals?** *Please check all that apply*

Bake  Boil  Broil  Fresh, Raw  Fry  Grill  Microwave

**How often do you eat take-out or fast food?**  Frequently  Never  Occasionally

# per day \_\_\_\_\_ # per week \_\_\_\_\_

### Mealtime Environment

**How often do you eat alone?**  Frequently  Never  Occasionally

**How often do you eat in bed?**  Frequently  Never  Occasionally

**How often do you eat at the computer?**  Frequently  Never  Occasionally

**How often do you eat at the dinner table?**  Frequently  Never  Occasionally

**How often do you eat while driving or riding public transportation?**  Frequently  Never  
 Occasionally

**How often do you eat while watching television?**  Frequently  Never  Occasionally

**Do you binge-eat?**  Yes  No

*If yes, what food(s)?* \_\_\_\_\_

### Eating Habits

**How often do you eat breakfast?**  Frequently  Never  Occasionally

**When are you most likely to eat breakfast?**  Weekday  Weekend  Everyday

*Usual time(s):* \_\_\_\_\_

**How often do you eat lunch**  Frequently  Never  Occasionally

**When are you most likely to eat lunch?**  Weekday  Weekend  Everyday

*Usual time(s):* \_\_\_\_\_

**How often do you eat dinner?**  Frequently  Never  Occasionally

**When are you most likely to eat dinner?**  Weekday  Weekend  Everyday

*Usual time(s):* \_\_\_\_\_

**How often do you skip meals?**  Frequently  Never  Occasionally

*Which meal(s) do you usually skip?* \_\_\_\_\_

**Do you get irritable, lightheaded, or weak if you don't regularly eat?**  Yes  No

*How often?*  Frequently  Never  Occasionally

**Do you use meal replacements? ( ex: Ensure)**  Yes  No

*What brand?* \_\_\_\_\_ *How often?*  Frequently  Occasionally

**Do you use artificial sweeteners?**  Yes  No

*What brand?* \_\_\_\_\_ *How often?*  Frequently  Occasionally

### Snacks

**What do you usually eat & drink for snacks?** \_\_\_\_\_

**How often do you eat foods or drinks from vending machines?**  Frequently  Never  
 Occasionally

**How often do you eat after dinner?**  Frequently  Never  Occasionally

*What do you eat?* \_\_\_\_\_

**If you awaken during sleep, do you eat food to fall back asleep?**  Yes  No

*If yes, How often?*  Frequently  Occasionally

### Beverages

**Do you drink alcoholic beverages?**  Frequently  Never  Occasionally

*# per day* \_\_\_\_\_ *# per week* \_\_\_\_\_

**Do you drink coffee or tea that contains caffeine?**  Frequently  Never  Occasionally

*# per day* \_\_\_\_\_ *# per week* \_\_\_\_\_

**Do you drink energy drinks?**  Frequently  Never  Occasionally

*# per day* \_\_\_\_\_ *# per week* \_\_\_\_\_

**Do you drink soda pop or sugary drinks?**  Frequently  Never  Occasionally

*# per day* \_\_\_\_\_ *# per week* \_\_\_\_\_

**Do you drink fruit juice or lemonade?**  Frequently  Never  Occasionally

*# per day* \_\_\_\_\_ *# per week* \_\_\_\_\_

**Do you drink herbal tea?**  Frequently  Never  Occasionally

*# per day* \_\_\_\_\_ *# per week* \_\_\_\_\_

### Exercise

**How often do you exercise?**  Frequently  Never  Occasionally

*# minutes per day* \_\_\_\_\_ *# times per week* \_\_\_\_\_

**Does anything prevent you from exercising?**  Yes  No

*If yes describe:* \_\_\_\_\_

**What type of exercise(s) do you do?** \_\_\_\_\_

**What type of exercise do you most enjoy?** \_\_\_\_\_

**What is the most convenient time for you to exercise?** \_\_\_\_\_

*Signature:* \_\_\_\_\_

*Date:* \_\_\_\_\_