

Nutrition History

Have you ever had a nutrition consultation? Yes No

Have you made any changes in your eating habits because of your health? Yes No Describe _____

Do you currently follow a special diet or nutritional program? Yes No

Check all that apply:

- Low Fat Low Carbohydrate High Protein Low Sodium Diabetic No Dairy
 Gluten Restricted Vegetarian Vegan Ultra-metabolism
 Specific Program for Weight Loss/Maintenance Type: _____ Other _____

Height (feet/inches) _____

Current Weight _____

Usual Weight Range +/- 5 lbs _____

Desired Weight Range +/- 5 lbs _____

Highest adult weight _____

Lowest Adult Weight _____

Weight Fluctuations (> 10 lbs.) Yes No

Body Fat % _____

How often do you weigh yourself? Daily Weekly Monthly Rarely Never

Do you avoid any particular foods? Yes No If yes, types of food and reason _____

If you could only eat a few foods a week, what would they be? _____

Do you grocery shop? Yes No If no, who does the shopping? _____

Do you read food labels? Yes No

Do you cook? Yes No If no, who does the cooking? _____

How many meals do you eat out per week? 0-1 1-3 3-5 >5 meals per week

Check all that apply to your current lifestyle and eating habits:

<input type="checkbox"/> Fast eater	<input type="checkbox"/> Significant other or family members have special dietary needs or food preferences
<input type="checkbox"/> Erratic eating pattern	<input type="checkbox"/> Love to eat
<input type="checkbox"/> Eat too much	<input type="checkbox"/> Eat because I have to
<input type="checkbox"/> Late night eating	<input type="checkbox"/> Have a negative relationship to food
<input type="checkbox"/> Dislike healthy food	<input type="checkbox"/> Struggle with eating issues
<input type="checkbox"/> Time constraints	<input type="checkbox"/> Emotional eater (eat when sad, lonely, depressed, bored)
<input type="checkbox"/> Eat more than 50% meals away from home	<input type="checkbox"/> Eat too much under stress
<input type="checkbox"/> Travel frequently	<input type="checkbox"/> Eat too little under stress
<input type="checkbox"/> Non-availability of healthy foods	<input type="checkbox"/> Don't care to cook
<input type="checkbox"/> Do not plan meals or menus	<input type="checkbox"/> Eating in the middle of the night
<input type="checkbox"/> Reliance on convenience items	<input type="checkbox"/> Confused about nutrition advice
<input type="checkbox"/> Poor snack choices	
<input type="checkbox"/> Significant other or family members don't like healthy foods	

The most important thing I should change about my diet to improve my health is:

Three-Day Diet Diary

List all food and drink that you typically have each day, including snacks.

	Day 1	Day 2	Day 3
Breakfast			
Lunch			
Dinner			
Snacks			

Comments:
