One Source Nutrition
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Registered Dietitian / Nutritionist

Dietitian History Questionnaire and Assessment

General Information:

Name: _____ Today's Date: _____

Occupation: _____ ___ Full time ___ Part time

Place of Employment: _____

Address: _____

Phone: _____ Phone #2: _____ Email: _____

Age: _____ Date of Birth: _____ Gender: _____

Reason for Appointment: _____

_____

_____

_____

Primary Care Provider: _____

_____

Address/Phone: _____

_____

Therapist: _____

_____

Address/Phone: _____

_____

Education level: ____Grammar School _____ High School _____ College _____ Graduate School

Marital Status: ___ Single ___ Married ___ Divorced ___ Separated ___ Widowed

Number of Children: _____

Age: _____ Date of Birth: _____ Gender: _____

Age: _____ Date of Birth: _____ Gender: _____

Age: _____ Date of Birth: _____ Gender: _____

Age: _____ Date of Birth: _____ Gender: _____

Age: _____ Date of Birth: _____ Gender: _____

Medical History:

Height: _____ Current Weight: _____

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: _____

List any medications you are currently taking or have taken in the last year:

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____
7. _____ 8. _____
9. _____ 10. _____

Are you currently taking any food or nutritional/herbal supplements? ___ Yes ___ No

If yes, please specify: _____

_____

_____

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

If yes, please specify: _____

_____

_____

Are you currently following that diet? ___ Yes ___ No

If not, 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 Explain: _____

Menstrual History: (Female Patient):
Are you currently menstruating? ___ Yes ___ No _____Have never menstruated
At what age did you get your first period? _____
Date of last menstrual cycle: _____ Weight at that time: _____ pounds
Are your periods regular? ___ Yes ___ No
Are you taking birth control pills / estrogen pills? ___ Yes ___ No
Do you experience PMS? ___ Yes ___ No
If yes, what are your symptoms? _____

Weight/Dieting History:
Have you tried to lose weight before? ___ Yes ___ No
How many times? _____ Age of first attempt: _____ years
What did you do? _____
Why did you go on that diet? _____

Have you ever used any of the following for weight control? If yes, please explain.
Commercial diet programs _____ Yes _____ No _____
Liquid diets _____ Yes _____ No _____
Fad diets _____ Yes _____ No _____
Prescription diet pills _____ Yes _____ No _____
Over-the-counter diet pills _____ Yes _____ No _____
Laxatives _____ Yes _____ No _____
Diuretics _____ Yes _____ No _____
Ipecac syrup _____ Yes _____ No _____
Vomiting _____ Yes _____ No _____
Self-designed program _____ Yes _____ No _____
Other _____
Do you experience periods during which you eat uncontrollably? ___ Yes ___ No
If yes, how often? _____
At what age did this begin? _____ years
Is this followed by:
_____ Vomiting Age began: _____ How often? _____
_____ Laxative use Age began: _____ How often? _____
_____ Excessive exercising Age began: _____ How often? _____
_____ Self harm Age began: _____ How often? _____
_____ Negative emotions Age began: _____ How often? _____

_____ Other (explain) _____

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

If yes, please explain: _____

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

If yes, please explain: _____

_____

Do you currently exercise for weight control? ___ Yes ___ No

Please explain: _____

Exercise History:

Do you exercise? ___ Yes ___ No

Please explain: _____

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

Please explain: _____

Are any members of your family underweight? ___ Yes ___ No

Please explain: _____

Does anyone in your family diet? ___ Yes ___ No

Please explain: _____

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

Please explain: _____

Does your family eat meals together? ___ Yes ___ No

What meals? _____

What is this like? _____

Eating Habits:

Do you skip meals? ___ Yes ___ No

How many days per week do you eat:

Breakfast: _____ Lunch: _____ Dinner: _____

Do you snack? ___ Yes ___ No

If so, 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

If yes, please specify: _____

What are your favorite foods? _____

Malnutrition Symptoms:

Do you now or have you ever experienced (for each checked, please add details to explain):

_____	Irregular menstrual periods	_____
_____	Absent menstrual periods	_____
_____	Cold intolerance	_____
_____	Tingling sensation in hands or feet	_____
_____	Headaches	_____
_____	Lightheadedness/Dizziness	_____
_____	Fainting	_____
_____	Sleeping difficulties	_____
_____	Skin changes	_____
_____	Hair loss	_____
_____	Hair growth on face and/or chest	_____
_____	Chest pains	_____
_____	Rapid heart beat	_____
_____	Shortness of breath	_____
_____	Mood swings	_____
_____	Episodes of crying for "no reason"	_____
_____	Frequently thinking about food	_____
_____	Confusion	_____
_____	Difficulty concentrating	_____
	Anxiety, especially around food	

_____ _____
_____ Less social interaction with family _____
_____ Frequently tired _____
_____ Memory problems _____
_____ Difficulty making decisions _____
_____ Problems with teeth _____
_____ Sore throat _____
_____ Swollen parotid glands _____
_____ Taste changes _____
_____ Constipation _____
_____ Diarrhea _____
_____ Muscle pain _____
_____ Joint pain _____
_____ Obsessive-compulsive behaviors _____
_____ Feelings of depression _____
_____ Other (explain) _____

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
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				

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
Breads				
Cereals				
Pasta, Noodles, Rice, Etc. (cup)				
Potatoes				
Commercial Baked Goods (cookies, donuts, cakes, etc.) (Serving)				
Cookies				
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				