



MPH, RD, CDN
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	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Liquid diets	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Fad diets	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Prescription diet pills	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Over-the-counter diet pills	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Laxatives	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Diuretics	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Ipecac syrup	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Vomiting	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Self-designed program	<input type="checkbox"/> Yes	<input type="checkbox"/> 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:

<input type="checkbox"/> Vomiting	Age began: _____	How often? _____
<input type="checkbox"/> Laxative use	Age began: _____	How often? _____
<input type="checkbox"/> Excessive exercising	Age began: _____	How often? _____
<input type="checkbox"/> Self harm	Age began: _____	How often? _____
<input type="checkbox"/> 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 _____

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

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				

