



## Your Nutrition Information

Please complete the following information and bring to your first session. If you are unsure about how to answer any of the questions, please leave them to discuss in the session.

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

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

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

May I contact you at: 1. Phone(Y/N)      2. Address (Y/N)      3. Email (Y/N)

Name of physician/therapist/other person who referred you:

\_\_\_\_\_

How would you describe your current problem?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Your medical history:

Other Medical Problems :

Treatment/Medications/Supplements:

1. \_\_\_\_\_

1. \_\_\_\_\_

2. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

3. \_\_\_\_\_

Food Allergies/Intolerances:

List any food allergies or intolerances you may have.

\_\_\_\_\_

\_\_\_\_\_

Please provide names and contact numbers of other physicians, psychiatrists or therapists involved in your healthcare:

1 \_\_\_\_\_

2 \_\_\_\_\_

3 \_\_\_\_\_

4 \_\_\_\_\_



**Your Nutrition Information**

**Height:** \_\_\_\_\_ **Weight:** \_\_\_\_\_

**Highest Adult Weight** \_\_\_\_\_ **Lowest Adult Weight** \_\_\_\_\_ **Desired Weight** \_\_\_\_\_

**Weight and Eating History:** (Please indicate the age or date that your difficulties with food, weight and eating began, what behaviors (restricting, overeating) contributed to the difficulties or the treatment you received (ie diets, weight management programs etc) and the weight change you experienced.

| <u>Age/Date when problems began:</u> | <u>Behavior/Treatment</u> | <u>Weight Change</u> |
|--------------------------------------|---------------------------|----------------------|
| _____                                | _____                     | _____                |
| _____                                | _____                     | _____                |
| _____                                | _____                     | _____                |
| _____                                | _____                     | _____                |

**Other comments:** \_\_\_\_\_

**Please indicate if you use any of the following substances and circle how many times a week or day you may use them.**

**Cigarettes: Y/N Packs per day/Frequency:** \_\_\_\_\_

**Alcohol: Y/N Type/Frequency** \_\_\_\_\_

**Drugs: Y/N Type /Frequency** \_\_\_\_\_

**Exercise :(Type/Frequency)**

**Please describe the types of exercise you do and include the length of time and the frequency per day or week.**

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## Your Nutrition Information

Please write down the number of times you may use the following behaviors and note how frequently you use them. Frequency(x per day/week/month)

1. How often do you diet/fast/use diet pills or cut back the amount of food/meals you eat? (Circle behaviors that apply) \_\_\_\_\_
2. How often do you feel out of control eating large quantities of food? (List the foods you would eat \_\_\_\_\_ ) \_\_\_\_\_
3. How often do you feel the need to remove food by vomitting after eating or bingeing? \_\_\_\_\_
4. How often do you exercise? \_\_\_\_\_
5. How often do you feel the need to exercise immediately after eating? \_\_\_\_\_
6. How often do you use laxatives/diuretics after eating? (How many?) \_\_\_\_\_
7. What percentage of your time do you spend thinking about food \_\_\_\_\_
8. How often do you wake up dreaming about food? \_\_\_\_\_
9. How often do you crave specific foods? (List types of foods craved \_\_\_\_\_) \_\_\_\_\_
10. How often do you eat when you are sad, bored, nervous, or angry? \_\_\_\_\_
11. How often do you look in the mirror and dislike your body? \_\_\_\_\_
12. How often do you weigh yourself? \_\_\_\_\_
13. How often does your weight affect your mood? \_\_\_\_\_
14. How often do you eat when you're hungry and stop when you're full? \_\_\_\_\_
15. How often does your work/school schedule affect how you eat? \_\_\_\_\_
16. How often do you feel guilty about eating? \_\_\_\_\_
17. How often is your eating affected by friends and family members' comments? \_\_\_\_\_
18. How often do you chew gum/eat candy/drink tea, coffee or soda/smoke? \_\_\_\_\_



**Your Nutrition Information**

To the best of your ability, please describe what a typical day of meals/snacks is like for you during the week and on the weekend. Please include all beverages and supplements consumed.

**Day:** **Daily Work/School Eating Pattern**

**Time:**

**Time:**

**Time:**

**Time:**

**Time:**

**Time:**



**Expectations of Nutrition Therapy**

**What do you expect to accomplish when working with the Nutrition Therapist?**

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**What would you like to learn about nutrition, food, eating behaviors and weight regulation?**

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**Is there any other information about your nutrition, weight and eating behaviors that would be helpful to the Nutrition Therapist?**

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