Nutrition History Form

Name: _____Date:_____

Date of Birth: _____ Height: _____
Current Weight: _____ Desired Weight: _____

Email/Contact information:

How long have you been at your current weight?

If your weight has changed, please describe what you did to gain or lose weight and indicate how long you have been working on changing your body composition.

What are your goals? Why are you seeing a dietitian?

Do you cook for yourself? If yes, how often and what types of foods do you prepare?

Do you grocery shop? _____
Do you want to change your eating habits? _____

How would you describe your eating habits? (Circle one.) Good Fair Poor

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Modified From American Dietetic Association, Sports Nutrition Assessment Package, 2006

Do you take any vitamin/mineral supplements? _____
If so, please list the types of supplements and the amounts the you take.

Do you take any other dietary supplements (creatine, echinacea, etc)? _____
If so, please list the types of supplements and the amounts that you take.

Are you allergic to any foods? _____ If so, please list them.

How often do you eat out? _____ times per week.
What types of restaurants do you visit (pizza, burgers, Chinese, etc)?

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Describe a typical day of activity/training and food intake (times, amounts, and types of foods and fluids consumed; and type of exercise with intensity, and duration of training).

Do you take any medications? _____ If so, please list the medications (both over-the-counter and prescription) that you currently take.

On the scale below, circle the number that indicates how ready you are to make dietary changes. 1 = not ready and 10 = very ready.

1	2	3	4	5	6	7	8	9	10

PLEASE BRING THIS FORM AND THE FOOD FREQUENCY FORM <u>COMPLETED</u> TO YOUR INITIAL VISIT WITH THE DIETITIAN. IF YOU ARE ALSO TESTING YOUR BLOOD GLUCOSE AT HOME, PLEASE BRING RECORDS TO ALL APPOINTMENTS.

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