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:_____**Phone:**_____

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.**_____

Date and Results of Last Physical:
Date and Results of Last Labwork:
Date and Results of Last EKG:
Date and Results of Last Bonescan:
If Applicable:Onset of Menstrual Periods:
Changes in Frequency of Menstrual Periods:
Date of Last Menstrual Period:

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_____

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Current Height:_____ Current Weight:_____

Highest Adult Weight_____ Lowest Adult Weight_____ Desired Weight_____

Weight and Eating History: Please indicate the age/date that your difficulties with food, weight and eating began, which behaviors(restricting, overeating, purging, exercising, dieting, weight management programs, etc,) you used and the resulting weight change you experienced.

Age/Date when problems began:	**Behavior/Treatment**	**Weight Change**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Other comments: _____

Please indicate if you use, or have used in the past, 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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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:

What were/are your family's views or rules about:

- **Healthy eating_____**
- **Healthy body weight_____**
- **Dieting_____**
- **Exercising_____**

Who in your family has the same body shape and size as you?(Think about aunts, uncles and grandparents as well as parents).

Who in your family eats and the same way as you?

Who in your family has the same activity level as you?

Which of the following information would you like to cover in your nutrition therapy sessions?

Food Groups_____ **Metabolism_____**

Factors influencing body weight_____ **Cravings_____**

Hunger/Satiety Signals_____ **Ideas for meals and snacks_____**

Emotional Eating_____ **Binge eating_____**

Goals for Nutrition Therapy

What do you expect to accomplish when working with the Nutrition Therapist? (ie. learn about nutrition, food, eating behaviors and weight regulation).