Nutrition First

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Nutrition First
Because it matters.

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NUTRITION HEALTH ASSESSMENT

BACKGROUND INFO

NAME (First, Last) _____
STREET _____
CITY, STATE, ZIP _____
TELEPHONE
Home (_____) _____ Work (_____) _____
Cell (_____) _____
EMAIL _____

PRIMARY CARE PHYSICIAN: _____
STREET _____
CITY, STATE, ZIP _____
Phone: _____ Email: _____

PRIMARY INSURANCE PROVIDER: _____
Primary Insurance Holder: _____ Relationship: _____
Group # _____ Member ID# _____

SECONDARY INSURANCE PROVIDER: _____
Secondary Insurance Holder: _____ Relationship: _____
Group # _____ Member ID# _____

GENDER: M_____ F_____
HEIGHT: _____ **CURRENT WEIGHT:** _____
AGE: _____ **DATE OF BIRTH :** _____

ETHNIC BACKGROUND
1. ____ White, not of Hispanic background
2. ____ Black, not of Hispanic Background
3. ____ Hispanic
4. ____ American Indian/Alaskan native
5. ____ Asian
6. ____ Pacific Islander

MARITAL STATUS
1. ____ Single
2. ____ Married
3. ____ Widowed
4. ____ Divorced/Separated

PRIMARY REASON FOR VISIT:

_____

_____

DIET HISTORY

Usual Weight _____
Have you lost or gained any weight over the past year? YES _____ NO _____
If yes, please explain.

_____

Do you have any food allergies or intolerances? YES _____ NO _____
If yes, please list.

_____
_____

Are you currently on a special diet? YES ____ NO ____
If yes, explain.

_____
_____

Have you followed any diets in the past? If so, please describe:

_____
_____
_____

How many times per week do you eat at restaurants or consume take-out or fast food?

_____

Please describe what you believe are your eating issues. (e.g. Do you have problems with portion control? Do you binge eat? Are you a stress eater?)

_____
_____
_____
_____

FOOD/BEVERAGE DIARY

Please record the time of day and your food and beverage intake for an average day.

Meal	Time	Food
Breakfast		
Snack		
Lunch		
Snack		
Dinner		
Snack		

Tips for Keeping an Accurate Food Diary

Your initial meal plan will be based largely upon your individual goals and your food recall. Keeping a food record will benefit our review of your current food habits. It may feel like an imposition, but this information will help us as we design an eating program to meet your specific needs. Here are some basic rules to help you document your eating habits:

- **Do it now**
  Do not depend on your memory at the end of the day to record your eating - record as you go. Keep your food record with you; write down ***everything*** you eat and drink, including the time. A piece of candy here, or a handful of pretzels there, a glass of juice, or a small donut may not seem like much, but knowing about these snacks will help us to better assess your needs and current food behaviors.

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- **Be specific**
  If you ate a burger with cheese, gravy on your meat, butter on your vegetables –write it all down. Be honest - if you eat French fries, don't write down potatoes – being fried makes a difference.

- **Estimate amounts**
  If you eat a piece of cake, estimate the size (2"x1"x3"). If you eat a vegetable, is it ½ cup or 2 cups? (a clenched fist is approximately a one cup serving). When eating meat, record the size or estimated weight (a piece that is the size of deck of cards is 3-4 oz; if the packaging label on your dinner steak says 1 ½ lbs., and you ate half of it, write down ¾ lb.)

Do the best you can!

MEDICAL HISTORY**

Have you or a blood-related family member ever been diagnosed with the following conditions?

Self / Family	Self / Family	Self/Family
□ □ Cardiac arrhythmia	□ □ Asthma	□ □ Hypothyroid
□ □ Elevated cholesterol	□ □ Stroke	□ □ Hyperthyroid
□ □ Diabetes Type I	□ □ Depression	□ □ Alcoholism
□ □ Diabetes Type II	□ □ Heart disease	□ □ Arthritis
□ □ Kidney Disease	□ □ High blood pressure	□ □ Overweight/obesity
□ □ Eating Disorder (specify)*	□ □ Cancer (specify type)*	□ □ Other (explain)*

*Explanation

_____

_____

In addition, please check all that apply to you.

Depression _____
Diverticulosis _____
Chronic constipation _____
Anemia _____
Nausea _____
Diarrhea _____
IBS _____
PCOS _____
Vomiting _____
Acid Reflux/GERD _____
Ulcers _____
Chronic fatigue _____
Smoker _____

Do you take vitamins/minerals or herbal supplements? YES ____ NO ____
If yes, please list.

_____

_____

List any medications you are currently taking.

_____

_____

Are you pregnant? Yes _____ No_____
If yes, how many weeks? _____
Are you breastfeeding? Yes _____ No _____

**If available, please bring a copy of recent lab work

ACTIVITY

Please complete the chart with activities you may do in your free time or practice regularly.

Activity and Intensity*	Length of Time (in minutes)	Times Per Week	Times Per Month

* Low = if you are moving but heart rate and breathing remain the same
  Moderate = if your breathing and heart rate increase
  High = if you are unable to carry on a conversation during the activity

SLEEP

What time do you usually go to bed? _____

What time do you usually wake up? _____

Do you usually feel rested when you get up? _____

OTHER

Please list any concerns or information you would like to discuss that have not been addressed anywhere within this form.

_____

_____

_____

_____