Original Date Given:
Date Received:

Nutritional History Questionnaire

All questions contained in the questionnaire are strictly confidential and will become part of your medical record. in the past.)

Name (Last, First, MI): _____ ☐ *M* ☐ *F* *DOB:* _____

Marital Status: ☐ *Single* ☐ *Partnered* ☐ *Married* ☐ *Separated* ☐ *Divorced* ☐ *Widowed*

Home Phone: _____ *Cell Phone:* _____ *Email:* _____

What is the main reason why you made an appointment with the nutritionist? _____

_____

Personal Health History

Weight: Height: _____ *BMI:*_____ *Body Fat:* _____ *(M=12-15%, F=18-22%)* _____

Waist Measurements: _____ *Arm Measurements: L:* ___ *R:* ___ *Thigh Measurements:* *L:* ____ *R:* ____

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Date	**Description and how many pounds you have lost**	**Have you kept it off? How much weight have you kept off or put on:**

Bariatric Surgery Patient

Will these sessions be a part of a Bariatric Nutritional Requirement Session? ☐ *Yes* ☐ *No*

If yes, how many required sessions needed? _____

Food	Do you eat organic food? ☐Yes ☐No	Do you belong to a food co-op? ☐Yes ☐No
	Rank salt intake ☐High ☐Med ☐Low	Rank fat intake ☐High ☐Med ☐Low
	Caffeine ☐None ☐Coffee ☐Tea ☐Cola	# of cups/cans per day? _____
Alcohol	Do you drink alcohol? ☐Yes ☐No	
	If yes, what kind? _____	
	How many drinks per week? _____	
	Have you ever experienced blackouts? ☐Yes ☐No	
Tobacco	Do you use tobacco? ☐Yes ☐No	
	Cigarettes - pks./day _____ Chew - #/day _____ Pipe - #/day _____ Cigars - #/day _____	
	# of years _____ Or year quit _____	
Drugs	Do you currently use recreational or street drugs? ☐Yes ☐No	
Sex	Are you pregnant? ☐Yes ☐No	If no, are you trying for a pregnancy? ☐Yes ☐No
Personal	Do you have frequent falls? ☐Yes ☐No	
Safety	Do you have vision hearing loss? ☐Yes ☐No	

Mental Health

Do you feel depressed? _____

Do you feel stressed? _____

Do you panic when stressed? _____

Do you have problems with eating or your appetite? _____

What Do You Want to Stabalize Your Health

(Check all of the conditions that you want to address with your nutritional plan and lifestyle change.)

☐ *Skin*
☐ *Weight Loss How much*
☐ *More Energy*
☐ *Weight Gain*
☐ *Hair*
☐ *Depression*
☐ *Chest/Heart Disease*
☐ *Diabetes*
☐ *Intestinal*
☐ *Hypertension*
☐ *Regular Bowel Movements*
☐ *Blood Circulation*

Recent changes in:

☐ *Weight*
☐ *Energy Level*
☐ *Ability to Sleep*
☐ *Other pain/discomfort*

Nutritionist Section Only

Blood Test Results Date Taken _____

Abnormalities _____

_____

_____

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers

Name the Drug and Product line of Vitamins (i.e.: Designs For Health Multivitamin)	Strength:	Frequency Taken:

Allergies to medications

Name the Drug	Reaction You Had

Health Habits and Personal Safety

All questions contained in this questionnaire are optional and will be kept strictly confidential.

Exercise	Sedentary (No exercise)
	Mild exercise (i.e.: climb stairs, walk 3 blocks, golf)
	Occasional vigorous exercise (i.e.: wok or recreation, less than 4x/week for 30 min.)
	Regular vigorous exercise (i.e.: work or recreation 4x/week for 30 minutes)
Physical	What part of your body that you want to change?
	☐ thighs ☐ check ☐ legs ☐ arms ☐ stomach ☐ cellulite ☐ buttock ☐ other:
Diet	Do you own a juicer?
	Are you a vegetarian?
	Are you dieting?
	If yes, are you on a physician prescribed medical diet?
	# of meals you eat in an average day?
	What kind of snacks do you love to eat?
	List foods that you dislike (all allergic foods need to be put in previous section):

What time of the day is your weakest time where you might go off your routine?
And what kind of food makes you go off your routine?
(if it is the same as the snacks you love to eat, then state "SAME AS ABOVE.")

Would you be willing to participate in a before and after Patient Testimonial video and photo?
Images and Videos are used for education purposes on our website, and in-house for other patients.

Before Image Taken: / / After Image Taken: / / Video: / /