Naples Nutrition ASSOCIATES, LLC

# Dietitian History Questionnaire and Assessment

**General Information:**

Name: _____ Today's Date: _____

Occupation: _____ Full Time Part Time

Place of Employment: _____

Address: _____

Phone #: _____ Phone #2: _____ Email: _____

Age: _____ Date of Birth: _____ Gender: F M

Reason for Appointment: _____

Primary Care Provider: _____

Address/ Phone: _____

Therapist: _____

Address/ Phone: _____

Education Level: ___ Elementary School ___ High School ___ College ___ Graduate School

Marital Status: ___ Single ___ Married ___ Divorced ___ Separated ___ Widowed

Number of Children: _____

Age: _____ Date of Birth: _____ Gender: _____

Age: _____ Date of Birth: _____ Gender: _____

Age: _____ Date of Birth: _____ Gender: _____

Age: _____ Date of Birth: _____ Gender: _____

Age: _____ Date of Birth: _____ Gender: _____

**Medical History:**

Height: _____ Current Weight: _____

***Please indicate whether you or a family member have/ had any of the following conditions:***

| Disease/ Condition | Self | Family | Relationship | Date/ Treatment |
|---|---|---|---|---|
| Asthma | | | | |
| Cancer | | | | |
| Cardiovascular Disease | | | | |
| Diabetes | | | | |
| Drug Dependency | | | | |
| Eating Disorder | | | | |
| Food Allergies | | | | |
| Food Intolerances | | | | |
| Kidney Disease | | | | |
| Headaches | | | | |
| Heart Attack | | | | |
| High Cholesterol | | | | |

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| | | | | |
|---|---|---|---|---|
| Hypertension | | | | |
| Intestinal Problems | | | | |
| Menstrual Problems | | | | |
| Mental Health Issues | | | | |
| Obesity | | | | |
| Osteoporosis | | | | |
| Other: | | | | |

Are you currently being treated for any medical conditions? _____ Yes _____ No
If yes, please specify: _____

List any medications you are currently taking or have taken in the last year:

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____
7. _____ 8. _____
9. _____ 10. _____

Are you currently taking any food or nutritional/ herbal supplements? _____ Yes _____ No
If yes, please specify: _____

Have you ever been advised by your physician to follow a special diet? _____ Yes _____ No
If yes, please specify: _____

Are you currently following that diet? _____ Yes _____ No
If not, why? If yes, what changes have you made? _____

Do you drink alcohol? _____ Yes _____ No Number of drinks per week: _____
Do you smoke cigarettes? _____ Yes _____ No Amount per day: _____
How long have you smoked? _____ If you quit smoking, when? _____
Do you use drugs? _____ Yes _____ No Explain: _____

**Menstrual History:** (Female Patient)
Are you currently menstruating? _____ Yes _____ No _____ Have never menstruated
At what age did you get your first period? _____
Date of last menstrual cycle: _____ Weight at that time: _____ pounds
Are your periods regular? _____ Yes _____ No
Are you taking birth control pills/ estrogen pills? _____ Yes _____ No
Do you experience PMS? _____ Yes _____ No
If yes, what are your symptoms? _____

**Weight/ Dieting History:**
Have you ever tried to lose weight before? _____ Yes _____ No
How many times? _____ Age of first attempt: _____ years
What did you do? _____
Why did you go on that diet? _____

Have you ever used any of the following for weight control? If yes, please explain:

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Commercial diet programs _____ Yes _____ No _____
Liquid diets _____ Yes _____ No _____
Fad diets _____ Yes _____ No _____
Prescription diet pills _____ Yes _____ No _____
Over-the-counter diet pills _____ Yes _____ No _____
Laxatives _____ Yes _____ No _____
Diuretics _____ Yes _____ No _____
Ipecac syrup _____ Yes _____ No _____
Vomiting _____ Yes _____ No _____
Self-designed program _____ Yes _____ No _____
Other: _____

Do you experience periods during which you eat uncontrollably? _____ Yes _____ No
If yes, how often? _____
At what age did this begin? _____ years
Is this followed by:

_____ Vomiting Age began: _____ How often? _____
_____ Laxative use Age began: _____ How often? _____
_____ Excessive exercising Age began: _____ How often? _____
_____ Self harm Age began: _____ How often? _____
_____ Negative emotions Age began: _____ How often? _____
_____ Other (explain) _____

Have you ever been diagnosed with an eating disorder? _____ Yes _____ No
If yes, please explain: _____
Are you currently or have you ever received treatment? _____ Yes _____ No
If yes, please explain: _____

Do you currently exercise for weight control? _____ Yes _____ No
Please explain: _____

**Exercise History:**

Do you exercise? _____ Yes _____ No
Please explain: Activity # days/ week how long

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

Do you have any physical conditions that limit your ability to exercise? _____ Yes _____ No
Please specify: _____

**Family Weight History:**

Are any members of your family overweight? _____ Yes _____ No
Please explain: _____
Are any members of your family underweight? _____ Yes _____ No
Please explain: _____
Does anyone in your family diet? _____ Yes _____ No
Please explain: _____
Did/ Does anyone in your family have an eating disorder? _____ Yes _____ No
Please explain: _____
Does your family eat meals together? _____ Yes _____ No
What meals? _____

What is this like? _____

**Eating Habits:**

Do you skip meals? _____ Yes _____ No

How many days per week do you eat:

Breakfast: _____ Lunch: _____ Dinner: _____

Do you snack? _____ Yes _____ No

If so, when? _____

Do you buy or pack your lunches? _____

_____ Buy # days/ week _____ _____ Pack # days/ week _____

Do you eat out? _____ Yes _____ No

How many meals per week? _____

What restaurants do you usually choose?

1. _____ 4. _____ 7. _____
2. _____ 5. _____ 8. _____
3. _____ 6. _____ 9. _____

Who usually prepares the food at home? _____

Do you know how to cook? _____ Yes _____ No

Who does the grocery shopping? _____

Do you read food labels? _____ Yes _____ No

What do you look at on the label? _____

| | | |
|---|---|---|
| Do the nutrition facts influence your decision to eat the food? | _____ Yes | _____ No |
| Do you eat standing up? | _____ Yes | _____ No |
| Do you eat in the car? | _____ Yes | _____ No |
| Do you eat while watching TV? | _____ Yes | _____ No |
| Do you eat while reading or on the computer? | _____ Yes | _____ No |
| Do you eat with others? | _____ Yes | _____ No |
| Do you eat fast? | _____ Yes | _____ No |
| Do you eat when bored? | _____ Yes | _____ No |
| Do you eat when stressed? | _____ Yes | _____ No |
| Do you eat when you are anxious? | _____ Yes | _____ No |
| Do you eat when you are lonely? | _____ Yes | _____ No |
| Do you eat when you are hungry? | _____ Yes | _____ No |
| Do you eat when you are not hungry? | _____ Yes | _____ No |
| Do you avoid certain foods? | _____ Yes | _____ No |

If yes, please specify: _____

What are your favorite foods? _____

**Review of Symptoms:**

Do you now or have you ever experienced (for each checked, please add details to explain):

_____ Irregular menstrual periods _____
_____ Absent menstrual periods _____
_____ Cold intolerance _____
_____ Tingling sensation in hands or feet _____
_____ Headaches _____

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_____ Lightheadedness/ Dizziness
_____ Fainting
_____ Sleeping difficulties
_____ Skin changes
_____ Hair loss
_____ Hair growth on face and/ or chest
_____ Chest pains
_____ Rapid heart beat
_____ Shortness of breath
_____ Mood swings
_____ Episodes of crying for "no reason"
_____ Frequently thinking about food
_____ Confusion
_____ Difficulty concentrating
_____ Anxiety, especially around food
_____ Less social interaction with family
_____ Frequently tired
_____ Memory problems
_____ Difficulty making decisions
_____ Problems with teeth
_____ Sore throat
_____ Swollen parotid glands
_____ Taste changes
_____ Constipation
_____ Diarrhea
_____ Muscle pain
_____ Joint pain
_____ Obsessive-compulsive behaviors
_____ Feelings of depression
_____ Other (explain): _____

**Goals/ Expectations:**

Do you want to change your eating habits? _____ Yes _____ No

Why? _____

Did you have any expectations from coming to see the nutritionist today? _____ Yes _____ No

Please explain: _____

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**Food Frequency Checklist**

Patient's Name: _____ Date: _____

| Check the Frequency the Following Foods Are Consumed | Never or Less than Once per Week | 1-2 Times Per Week | 3-7 Times Per Week | More than Once a Day |
|---|---|---|---|---|
| Beef | | | | |
| Sausage, Bacon, Lunchmeat | | | | |
| Pork | | | | |
| Poultry | | | | |
| Poultry –Prebreaded ie: nuggets | | | | |
| Poultry – Fried | | | | |
| Fish | | | | |
| Fish – Prebreaded ie: fish sticks | | | | |
| Fish – Fried | | | | |
| Shellfish | | | | |
| Beans | | | | |
| Peanut Butter | | | | |
| Pizza | | | | |
| Milk (Specify Type) | | | | |
| Cream | | | | |
| Cheese | | | | |
| Cheese – Regular | | | | |
| Cheese – Low Fat | | | | |
| Cheese – Non-Fat | | | | |
| Yogurt | | | | |
| Ice Cream | | | | |
| Frozen Yogurt | | | | |
| Eggs | | | | |
| Oils | | | | |
| Butter | | | | |
| Margarine | | | | |
| Vegetables | | | | |
| Fruits | | | | |
| Fruit Juice | | | | |
| Breads | | | | |
| Cereals | | | | |

| | | | | |
|---|---|---|---|---|
| Pasta, Noodles, Rice, Etc. (cup) | | | | |
| Potatoes | | | | |
| Commercial Baked Goods (cookies, donuts, cakes, etc.) | | | | |
| Cookies | | | | |
| Soft Drinks (Non-Diet) (Serving) | | | | |
| Snack Crackers (Serving) | | | | |
| Nuts and Seeds (1/4 Cup) | | | | |
| Potato Chips or Corn Chips (Cup) | | | | |
| Sherbets and Ices (1/2 Cup) | | | | |
| Candy | | | | |
| Frozen Meals | | | | |
| Chinese Food | | | | |
| Fast Food | | | | |