

Nutrition Therapy Associates

Nutrition Assessment / Intake Form

Name: _____ Date: _____

Phone – Home: _____ Cell: _____ Work: _____

Address: _____

Email: _____ Profession: _____

Reason for appointment: _____ How did you hear about us? _____

Have you ever worked with a Nutrition Therapist? Yes No If yes, who: _____

Please list names of any of the following professionals with whom you are working:

Therapist: _____ Physician: _____

Psychiatrist: _____ Trainer: _____

Age: _____ DOB: _____ Ht: _____ Wt: _____

Are you currently being treated for any medical conditions: Yes No Specify: _____

List medications you are currently taking: _____

Are you following a special diet? Yes No Specify: _____

List food and/or vitamin/mineral supplements you are taking: _____

Weight History

Do you weigh yourself? Yes No How often? _____

Your highest weight: _____ Age _____ Lowest weight: _____ Age _____ Desired wt: _____

"Set point" is a weight where the body tends to stabilize with normal eating. What do you think your set point weight is? _____ Last time you weighed this? _____ For how long? _____

How many calories do you think you need to maintain your current weight? _____

How many calories do you think you need to maintain your desired weight? _____

What is your family's attitude about health? _____

What is your family's attitude about weight? _____

Check to indicate which family members:

Try to eat healthfully: Mom Dad Sister Brother Partner Grandparents

Try to control their weight: Mom Dad Sister Brother Partner Grandparents

Are "overweight": Mom Dad Sister Brother Partner Grandparents

Menstrual History – men skip to next section

Are you currently menstruating: Yes No Have never menstruated Age began: _____

Approximate weight at time of first menstruation: _____ Approximate height: _____

Date last menstrual cycle: _____ Average weight fluctuation during menstrual cycle? _____

Are you taking birth control pills/estrogen pills? Yes No

Do you experience PMS? Yes No Describe: _____

As you lose weight, do your cycles become irregular or cease? Yes No At what weight? _____

Eating Patterns

Describe what hunger feels like to you: _____

Describe what fullness feels like to you: _____

How do you know when to quit eating? _____

- Yes No I usually eat when I get hungry
- Yes No I often eat when I'm not hungry
- Yes No I can tell the difference between physical hunger and "emotional hunger"
- Yes No Nutrition facts influence my decisions about what to eat. Check all that apply:
___Calories ___Carb ___ Fat ___Vitamins ___ Minerals Other: _____
- Yes No I try to follow a very specific meal plan.
- Yes No I find it almost impossible to follow a specific meal plan.

- | | |
|--|---|
| <input type="checkbox"/> Yes <input type="checkbox"/> No I eat standing up | <input type="checkbox"/> Yes <input type="checkbox"/> No I eat faster than others |
| <input type="checkbox"/> Yes <input type="checkbox"/> No I eat in the car | <input type="checkbox"/> Yes <input type="checkbox"/> No I eat slower than others |
| <input type="checkbox"/> Yes <input type="checkbox"/> No I eat while watching TV | <input type="checkbox"/> Yes <input type="checkbox"/> No I eat when stressed |
| <input type="checkbox"/> Yes <input type="checkbox"/> No I eat while reading | <input type="checkbox"/> Yes <input type="checkbox"/> No I eat when bored |
| <input type="checkbox"/> Yes <input type="checkbox"/> No I eat while on the computer | <input type="checkbox"/> Yes <input type="checkbox"/> No I eat when anxious |
| <input type="checkbox"/> Yes <input type="checkbox"/> No I eat with others | <input type="checkbox"/> Yes <input type="checkbox"/> No I eat when lonely |

What are your favorite foods? _____

What food don't you like? _____

List foods you typically avoid: _____

Do you drink alcohol? Yes No Number of drinks/wk: _____

Do you use drugs? Yes No Explain: _____

Do you smoke cigarettes? Yes No Quit Do you chew gum? Yes No A lot

Check any of the following that describes your **recent** eating patterns:

- | | | |
|--|---|--|
| <input type="checkbox"/> Eat 3 meals a day. | <input type="checkbox"/> Graze most of the day | <input type="checkbox"/> Induce vomiting |
| <input type="checkbox"/> Eat 3 meals with snacks | <input type="checkbox"/> "Overeat" most of the day | <input type="checkbox"/> Use laxatives |
| <input type="checkbox"/> Eat less than most others | <input type="checkbox"/> Restrict amount of food consumed | <input type="checkbox"/> Use diuretics |
| <input type="checkbox"/> Eat more than most others | <input type="checkbox"/> Restrict types of foods consumed | <input type="checkbox"/> Exercise excessively |
| <input type="checkbox"/> Eat basically "normally" | <input type="checkbox"/> Binge eat | <input type="checkbox"/> Self harm in response to eating |

Dieting History

How many times have you tried to control your weight? _____
Age at first attempt: _____ years Your height at that time? _____ Weight? _____
What did you do? _____
Why did you go on the diet? _____

Have you ever used any of the following in an attempt to control your weight? Add any comments such as your age(s), how effective you thought it was, etc.

- Yes No Eat "healthfully" _____
- Yes No Exercise _____
- Yes No Count calories/carbs _____
- Yes No Weight Watchers _____
- Yes No Other diet programs _____
- Yes No Low carb diets _____
- Yes No Liquid diets _____
- Yes No Fad diets _____
- Yes No Prescription diet pills _____
- Yes No Over-the-counter pills _____
- Yes No Laxatives _____
- Yes No Diuretics _____
- Yes No Ipecac Syrup _____
- Yes No Vomiting _____
- Yes No Self designed program _____
- Yes No Intuitive eating _____
- Yes No Negative self-talk _____
- Yes No Other: _____

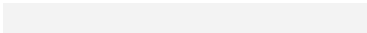
Do you eat uncontrollably at times? Yes No Age(s): _____

Describe: _____

- Is this followed by: Vomiting Laxative Use Excessive Exercising
 Dieting Self-Harm Negative Emotions
 Other (explain) _____

Have you ever been diagnosed with an eating disorder? Yes No Please explain: _____

Additional thoughts about your attempts to control weight and what you feel needs to happen now: _____



Disordered Eating Behaviors

Please check if you experience any of the following:

<input type="checkbox"/>	I avoid eating a food if I don't know how it was prepared
<input type="checkbox"/>	I avoid eating a food if I don't know it's nutritional content
<input type="checkbox"/>	I won't eat unless I'm able to exercise or purge afterward
<input type="checkbox"/>	I become upset if I am unable to eat at a certain time
<input type="checkbox"/>	I become upset if I eat foods other than what I planned
<input type="checkbox"/>	I eat foods that are different from the rest of my family

<input type="checkbox"/>	I count calories	<input type="checkbox"/>	I won't eat in front of others
<input type="checkbox"/>	I count fat grams	<input type="checkbox"/>	I have safe foods and unsafe foods
<input type="checkbox"/>	I count carbohydrate grams	<input type="checkbox"/>	My eating is very ritualized
<input type="checkbox"/>	I count protein grams	<input type="checkbox"/>	I compare what I eat to what others eat
<input type="checkbox"/>	I count Weight Watchers points	<input type="checkbox"/>	I hide food so others will think I ate it
<input type="checkbox"/>	I cut my food into small pieces	<input type="checkbox"/>	I hide food so I can binge
<input type="checkbox"/>	I weigh / measure my food	<input type="checkbox"/>	I feel guilty after eating
<input type="checkbox"/>	I refuse to eat after a certain hour	<input type="checkbox"/>	I believe there are good foods / bad foods
<input type="checkbox"/>	I eat the same foods daily	<input type="checkbox"/>	I feel ashamed of my eating
<input type="checkbox"/>	I'm scared to try new foods	<input type="checkbox"/>	Food seems to be controlling my life

Exercise History

Are you currently exercising? Yes No Describe: _____

Describe your past history with exercising: _____

Do you / have you ever exercised compulsively? Yes No At what ages: _____

Do you have any physical conditions that limit your ability/safety to exercise? Yes No
Describe: _____

Your Specific Needs and Hopes

What would you like to achieve as a result of nutrition counseling. Please note anything else you feel we should know.

Thank you for choosing Nutrition Therapy Associates. We look forward to assisting you in your journey towards freedom from eating and weight related issues.