NUTRITIONAL HISTORY

Have you ever had a nutrition consultation? YES / NO

Have you ever made changes in your eating habits due to health reasons? YES / NO

If yes, describe: _____

Do you currently follow a special diet or nutritional program? YES / NO

Check all that apply:

- **□ Low Fat** **□ Low Carbohydrate** **□ Low Sodium** **□ Diabetic**
- **□ No Dairy** **□ Gluten Restricted** **□ No Wheat** **□ Vegetarian**
- **□ Vegan** **□ Ultrametabolism** **□ Other _____**
- **□ Specific Program for Weight Loss/Maintenance Type:_____**

Current Height (feet/inches)	**Current Weight**
Usual Weight Range +/- 5 lbs.	**Desired Weight Range +/- 5 lbs.**
Highest Adult Weight	**Lowest Adult Weight**
Weight Fluctuations > 10 lbs. YES / NO	**Body Fat %**

How often do you weigh yourself? □ Daily □ Weekly □ Monthly □ Rarely □ Never

Have you ever had your metabolism (resting metabolic rate) checked? □ Yes, where _____ □ No

Do you avoid any particular foods? □ No □ Yes, types and reason _____

_____

_____

If you could only eat a few foods a week, what would they be? _____

_____

Do you grocery shop? □ Yes □ No If no, who does the shopping? _____

Do you read food labels? □ Yes □ No

Do you cook? □ Yes □ No If no, who does the ? _____

How many meals do you eat out per week? □ 0-1 □ 1-3 □ 3-5 □ >5 meals per week

Check all the factors that apply to your current lifestyle and eating habits:

- **□ Fast eater**
- **□ Erratic eating pattern**
- **□ Eat too much**
- **□ Love to eat**
- **□ Late night eating**
- **□ Dislike healthy foods**
- **□ Time constraints**
- **□ Travel Frequently**
- **□ Do not plan meals or menus**
- **□ Reliance on convenience items**
- **□ Poor snack choices**
- **□ Confused about nutrition advice**
- **□ Family member with special dietary needs/preferences**
- **□ Eat because I have to**
- **□ Have a negative relationship with food**
- **□ Family members don't like healthy foods**
- **□ Struggle with eating issues**
- **□ Emotional eater**
- **□ Eat more than 50% of meals away from home**
- **□ Eat too much under stress**
- **□ Eat too little under stress**
- **□ Don't care to cook**
- **□ Eating in the middle of the night**
- **□**

The most important thing I should change about my diet to improve my health is: _____

_____

Patient Name: _____ Date of Birth: _____