power nutrition

Sports Nutrition • Eating Disorders • Weight Mangament • Gastrointestinal Health

Health & Nutrition Questionnaire

Date_____ Name _____ DOB_____

Address:_____ City_____ ST_____ Zip_____

email:_____ contact #:_____

Ht_____ Wt (usual)_____ Wt. (current)_____

MEDICAL HISTORY

Reason for today's consultation:_____

Referring Physician:_____

Primary Care Physician:_____ Therapist (if applicable):_____

Currently following a special diet, (i.e. low salt, gluten free)_____

___Non-smoker ___ Smoker, amt/day_____ ___Former smoker, date quit_____

___Alcohol/drug abuse
___Anemia
___Anorexia/bulimia (current/past)
___Constipation/diarrhea
___Diabetes/gestational
___Depression
___Heart disease
___High blood pressure
___High cholesterol_____
___Kidney
___Liver
___Nervousness
___Osteoporosis
___Overweight
___Rapid weight loss_____
___Thyroid condition
___Ulcer
___Other_____

DIET & FOOD HISTORY

Vitamin/mineral supplements_____

Number of times/week do you eat out?_____ Which meals_____

Type of restaurant visit most frequently?
___Fast food ___Cafeteria ___Family dining ___Fine dining

Grocery shopping for household
___Self ___Spouse/partner ___Roommate ___Other

Meals planned in advance?_____

Problem foods and/or food allergies:_____

Symptoms relating to current gastrointestinal distress:_____

Please continue if the reason for your consult relates to weight management issues, otherwise SKIP to *Exercise History* to complete form.

Yo-yo dieter?_____

Weight in past year: Weighed the same_____ Steadily lost weight, amount_____
Lost & gained_____ Steadily gained weight, amount_____

Body weight satisfaction Not at all Moderately Extremely
1 2 3 4 5 6 7 8 9

Over lifetime, number of times tried to lose weight?_____

"Diet" programs tried in past?
___Restricted calorie diet ___High protein diet (Atkins) ___Diet pills
___Packaged food diet ___Shake diet (Slim fast) ___Single/combo food diet
___Weight loss programs (Weight watchers, Jenny Craig) ___Other

Success seen with such diets/programs
___Lost weight and kept it off, amount_____ ___Did not lose weight
___Lost weight and gained it back, amount_____ ___Other_____

Meals eaten regularly:___Breakfast ___Lunch ___Dinner ___Snack(s)
Number of 8-oz glasses of water/day_____
Other fluids commonly consumed_____

Reasons describing why you eat
___Hectic schedule ___Like food too much ___Have sweet tooth
___Like to cook ___Social obligations ___Depression
___Hunger ___Emotional stress ___Fatigue
___Frustration ___Anger ___Other_____

EXERCISE HISTORY
Current exercise habits:

Type of exercise	**Frequency (per week)**	**Duration (time)**	**Intensity**
_____	_____	_____	_____
_____	_____	_____	_____

Nutrition and Health Goals: (Long, medium, short-term)

_____
_____
_____
_____

VISIT NOTES: