HEALTH AND NUTRITION HISTORY

Client Information

Please take a moment to complete this form in ink. Some questions may not apply and may be left unanswered. The information you share will help the Registered Dietitian have a better understanding of your needs. Please bring this questionnaire with you to your appointment.

***Please note**: South Denver Cardiology Assoc. does not bill insurance for nutrition services. Please check with your insurance company to see if you're covered prior to your scheduled appointment. We request payment at time of service. We will be happy to give you a superbill or encounter form in order for you to bill your insurance company.*

***Nutrition Services**:*
$80 for initial 1 hour assessment
$50 for each ½ hour follow-up

(Please Print)

Today's Date: _____

Name_____ Date of Birth: _____

Address_____

Home Phone #:_____ Work Phone (optional):_____

E-Mail_____

Sex: ___Female ___ Male Occupation: _____

Referring Physician _____

Reason for nutrition consult _____

Height: _____ Weight: _____

MEDICAL HISTORY

CONDITION	YES	NO	COMMENTS
High blood pressure			
Hyperlipidemia (high cholesterol)			
Cardiovascular disease			
Type 2 diabetes			
Metabolic Syndrome			
Sleep Apnea			
Asthma			
Arthritis			
Depression			
Thyroid condition			
Gastrointestinal disorders			
Gall bladder disease			

Renal disease			
Liver disease			
Pacemaker			
Cancer			
Eating Disorder			
Chronic Constipation			
Migranes			
Irritable Bowel Syndrome			
Celiac Disease/Gluten Intol.			
Other:			

List any recent surgeries:
_____

Food allergies/intolerances:
_____

List all medications:_____

_____

Do you take any vitamin, mineral, herbal or other dietary supplements?

- ❑ Yes List: _____
- ❑ No

LABS:

Total cholesterol: _____ LDL Cholesterol: _____ HDL Cholesterol: _____

Triglycerides: _____ Glucose: _____ C-Reactive Protein: _____

HgA1c: _____

Family History: ☐ Diabetes (Type: _____) ☐ Heart Disease ☐ Osteoporosis

☐ High blood pressure ☐ Stroke ☐ Thyroid disorder

☐ Heart Attack ☐ Cancer (Type: _____)

☐ Alcoholism ☐ Other: _____

NUTRITION HISTORY

1. Are you concerned about your weight?

- ❑ No (Skip to question 7)
- ❑ Yes, I want to stop gaining weight. (Skip to question 4)
- ❑ Yes, I want to lose weight. (Go to question 2)

2. What do you think weighing less would do for you?

In the next few months:

_____

_____

In the next year or two:

_____

_____

3. What is your goal weight? _____lbs.
How long ago were you at this weight? _____

4. Fill in the blank for each of the following perceived weights:
_____ Ideal Weight
_____ Happy Weight
_____Acceptable Weight
_____ Disappointed weight

5. What was your lowest adult weight? _____ Age at this weight? _____

6. What was your highest adult weight? _____ Age at this weight? _____

7. Do you smoke cigarettes?
- ❑ Yes- How many in a typical day? _____
- ❑ No

8. Are you currently on a diet or taking prescribed or across-the-counter medication to lose weight or to maintain your current weight?
- ❑ No
- ❑ Yes, I am on a diet. Describe the diet.

  _____
- ❑ Yes, I am on these weight-loss medications:

9. Have you tried to lose weight in the past?
- ❑ No (Skip to question 11)
- ❑ Yes-check all that apply.
  - ❑ Diet(s) Describe.

    _____
  - ❑ Medications List.

    _____
  - ❑ Other Describe.

    _____

10. If yes to number 9, did you lose weight?

- ❑ No
- ❑ Yes _____lbs. over this period of time: _____

How much of this weight, if any, did you gain back? _____lbs.

What worked best for you and why?

_____

11. In the past year, have you tried to lose weight or control your weight by vomiting, taking diet pills or laxatives, or not eating?

- ❑ Yes
- ❑ No

12. Do you feel that your eating is out of control or that you are eat when you are stressed/bored/lonely etc?

- ❑ No
- ❑ Yes-explain:

_____

13. Do you participate in regular physical activity?

- ❑ No
- ❑ Yes Describe:

LIST YOUR ACTIVITES	HOW MANY TIMES A WEEK DO YOU DO THIS ACTIVITY?	HOW MUCH TIME DO YOU SPEND IN THIS ACTIVITY IN A TYPICAL WEEK?
1.		
2.		
3.		

List any limitations for physical activity _____

Do you frequently experience: ☐ Diarrhea ☐ Constipation ☐ Bloating/gas ☐ Dry skin
☐ Heartburn/reflux ☐ Light-headed/dizzy ☐ Colds/flu
☐ Water retention ☐ Sinus problems ☐ Headaches
☐ Allergies ☐ Mood swings ☐ Muscle twitches ☐ PMS
☐ Bleeding gums ☐ Easy bruising ☐ Canker sores
☐ Brittle nails ☐ Tingling in fingers/toes

14. Put an X on the line below to show, on a scale from 0 to 10, how you rate your knowledge level regarding general nutrition?

……..

0	5	10
I don't know anything	I know the basics	I am an expert

15. How would you rate the application of your nutrition knowledge to your everyday lifestyle?

……..

0	5	10
I never eat healthy	I eat healthy 3 times per week	I eat healthy daily

16. Put an X on the line below to show, on a scale from 0 to 10, how important it is for you to make lifestyle changes? (Lifestyle changes are changes to improve your health, such as adjusting your diet, increasing your physical activity, and changing health-related behaviors.)

……..

0	5	10
Not very important	Somewhat important	Very important

17. Put an X on the line to show how ready you are right now, on a scale of 0 to 10, to make lifestyle changes.

……..

0	5	10
Not very ready	Somewhat ready	Very ready

18. Put an X on the line to show how confident you are, on a scale of 0 to 10, that you can make lifestyle changes?

……..

0	5	10
Not very confident	Somewhat confident	Very confident

19. What lifestyle changes would you be willing to make?

_____

20. How much time would you be willing to spend each week on making lifestyle changes? (for example, attending classes, reading info, tracking foods eaten and activity)

_____

21. What barriers or obstacles will challenge you in reaching your goal?

___ Lack of nutrition knowledge

___ Lack of time/hectic schedule

___ Lack of organization

___ Don't like to cook

___ Don't know how to cook

___ Emotional eating (overeating or not eating enough due to stress, boredom, anxiety, loneliness, being scared or sad, happy/relaxed)

___ Other: _____

22. Put an X on the line to show your current level of stress, on a scale of 1 to 5.

……..

1	3	5
Very relaxed	Managing OK	Very stressed

23. Do you feel you have a good support system to help you accomplish your goals?

_____

25. Check any that apply:

- ❑ My family eats most meals together.
- ❑ I eat most of my meals alone.
- ❑ Family meals are served at regular times on most days.
- ❑ Another member of my family is on special diet or is trying to lose weight.

26. Check the type of food you and/or your family eat and how many times in a typical week:

- ❑ Heat and serve meals _____
- ❑ Home-cooked meals _____
- ❑ Fast foods _____
- ❑ Restaurant _____
- ❑ Take out _____
  (Grocery or Restaurant)

27. After completing this health and nutrition history, what is your most important goal you want nutrition counseling to help you reach?

_____

Typical Day

Write down the typical foods you eat from day to day under the appropriate column. Write down everything that passes your lips, including fluid intake, as well as solid food. Please be as specific as you can and note the amount (for example: “8 oz 2% milk” instead of “glass of milk.”

Breakfast	Snack	Lunch	Snack	Dinner	Snack