Nutrition Intake Form

Referring Physician: _____ **Name:** _____

Phone: _____

What would you like to gain from meeting with a dietitian?

Have you seen a dietitian before?

◯ Yes ◯ No

If yes, was it within the past 12 months?

◯ Yes ◯ No

Have you ever been told by a doctor that you have diabetes?

◯ Yes ◯ No

If yes, at what age?: _____

Have you ever had diabetic education by a Certified Diabetic Educator or a dietitian?

◯ Yes ◯ No

What has been your...

Lowest weight: _____ **Age at lowest weight:** _____

Highest weight: _____ **Age at highest weight:** _____

What is your weight goal?: _____

Weight goal preference:

◯ Weight loss ◯ Weight gain ◯ Weight maintenance

In the last 3 months, how many times per week have you participated in physical activity resulting in an elevated heart rate for at least 30 continuous minutes, such as jogging, swimming, rapid walking, biking, stair stepping, dancing, etc.?

◯ 1
◯ 2
◯ 3
◯ 4
◯ 5
◯ 6
◯ 7
◯ I have a physical disability that prevents me from exercising

If you participate in physical activity, please list type(s) and duration of activity. If none, state none.

How long have you been participating in the above stated activities?

How physically active is your daily routine?

◯ Not active ◯ Light ◯ Moderate ◯ Heavy

Do you have any kind of physical limitations? If so, please describe:

Do you do the grocery shopping?

◯ Yes ◯ No ◯ Some

Do you do the cooking at home?

◯ Yes ◯ No ◯ Some

How often do you eat out during a typical week?:

Where do you typically eat?

Do you smoke?

◯ Never ◯ In the past ◯ Currently

Do you consume alcohol?

◯ Yes ◯ No

If yes, how often?: _____

Do you eat, drink, or use any of the following:

- ☐ Protein drinks
- ☐ Coffee
- ☐ Diet soda
- ☐ Laxatives
- ☐ Fast foods
- ☐ Chips
- ☐ Artificial sweeteners (blue, pink, yellow)
- ☐ Appetite suppressants
- ☐ Decaf coffee
- ☐ Soda
- ☐ Margarine or butter
- ☐ Fried foods
- ☐ Salt (without tasting)
- ☐ Coffee creamers

Are you allergic to any foods?

◯ Yes ◯ No

If yes, please specify:

Do you have any food intolerances/sensitivities?

◯ Yes ◯ No

If yes, please specify:

Are there certain foods that you avoid from your diet?

◯ Yes ◯ No

If yes, please specify:

Have you ever been told by a doctor to follow a specific nutrition plan (weight loss, diabetic, low cholesterol, etc.)?

◯ Yes ◯ No

Are you currently following a nutrition plan (i.e. diabetic, gluten free, low lactose, low cholesterol, etc.)?

◯ Yes ◯ No

If yes, please specify:

What have been some of your health challenges/obstacles that you encountered in the past?

- ☐ Limiting sweets/desserts
- ☐ Lack of motivation
- ☐ Emotional eating (stress, upset, happy, etc.)
- ☐ Feeling overly hungry
- ☐ Eating when not hungry
- ☐ Chewing/swallowing
- ☐ Unsure about what to eat
- ☐ Difficulty with shopping
- ☐ Financial challenges
- ☐ Eating too large of quantities
- ☐ Limiting high sugar beverages
- ☐ Eating too fast
- ☐ Lack of physical activity (not seeing results)
- ☐ Food cravings
- ☐ Skipping meals
- ☐ Lack of appetite
- ☐ Difficulty with cooking
- ☐ Problems with goal setting

Is there anything else about either your history or your current condition that you feel is important to mention?

What changes are you ready to make within the next 30-60 days to improve your overall health?