Sound Nutrition

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Physical Activity and Nutrition Appraisal

Please complete this nutrition assessment form and bring it to your first session. Completing this form prior to our appointment will save time during the session and allow us to maximize our time together.
Please call with any questions!

Date:_____
Name: _____ Date of Birth:_____
MD: _____
Therapist: _____
Psychiatrist: _____

Reason for seeking nutrition counseling:
_____
_____

What goals do you hope to achieve as a result of nutrition counseling?
_____
_____

Where do you get most of your nutrition information?_____
_____
_____

List any diets you have tried including commercial diet programs, diets written about in books, and those that you have developed yourself and indicate your age at the time. Give a brief description of the dieting technique involved.

Book title, diet or program **Your age** **Brief description**

_____
_____
_____
_____
_____

Age: _____ Sex: _____ Height: _____

For Office use
*CW*_____
*GW*_____
*P/Lx/D*_____
*DOLP*_____
*Scale*_____
*Kcals*_____

Weight History:
Low weight: _____ age _____
High weight: _____ age _____
Usual weight: _____

Current Medications: _____
_____

Date/Results of bone density scan:_____

Vitamin/mineral
Supplements: _____
(brand/amount) _____

Chronic Medical Conditions: _____

Surgeries (when/why): _____

Allergies: _____

Family Medical History:
Does or has anyone in your family had any of the following?

Polycystic Ovarian Syndrome_____ Disordered Eating_____
Heart Disease _____ Hypertension_____
Diabetes_____ Hypoglycemia_____
Depression_____

Do you or have you experienced any of the following?

Hair loss	yes/no	Esophageal reflux	yes/no
Dry skin	yes/no	Stomach aches	yes/no
Dizziness	yes/no	Constipation	yes/no
Fatigue	yes/no	Diarrhea	yes/no
Fainting spells	yes/no	Bloating	yes/no
Headaches	yes/no	Cold intolerance	yes/no
Hypoglycemia	yes/no	Irregular menses	yes/no/doesn't apply
Sleep disturbance	yes/no	Abnormal lab values	yes/no
Acne	yes/no	High blood pressure	yes/no
Dark skin patches	yes/no	High cholesterol	yes/no

Exercise History:
Do you exercise? _____If yes:

Type	Frequency	Duration
_____	_____	_____
_____	_____	_____
_____	_____	_____

How long have you been on this exercise program?_____

Participation in sports/athletics_____
_____

Past experience with athletics/sports_____
_____

Did you ever exercise compulsively?_____
_____

How do you feel about your weight/body now?_____
_____

How did you feel about body in elementary school? _____
Intermediate school? _____
High School? _____
College? _____

When/why did it change? _____
_____

Eating behavior
Who plans your meals? _____ Who cooks?_____Who shops? _____

What are your favorite foods?_____
_____

Do you currently eat all of these? _____
If not, why?_____

Are there foods you consider “good”?_____
_____
Are there foods you consider “bad”? _____
_____

What is your definition of normal eating:_____
_____
_____

What changes have you made in your diet in the past?_____
_____

Did you maintain those changes?_____For how long?_____

How did you maintain changes? What helped?_____
_____

What difficulties did you encounter?_____

How do you feel about your current diet?_____
_____

What would you like to change about your diet right now?_____
_____
Why?_____

What concerns do you have about changing your diet now?_____
_____

Describe what hunger feels like to you:_____
_____

Describe what fullness feels like to you:_____
_____

How do you know when to stop eating?_____
_____

Describe the eating style of those closest to you, including friends/roommates/family (Would you consider them normal eaters?)._____
_____
_____
_____
_____
_____

What does a typical day look like? Please include fluids, including alcoholic beverages.

Time	Place	Food	Amount	Feelings

Chew gum, drink caffeine, smoke cigarettes?_____