To Patient:
Please complete the following form and bring it with you to your first appointment.

New Patient Intake Form

General Information:

Name: _____ Date: _____
Age: _____ Date of Birth: _____ Gender: _____
Reason for Appointment: _____

_____

_____

_____

Employment Status: ___ Full Time ___ Part Time ___ Not Employed
Occupation: _____
Place of Employment: _____
Education level: ____Grammar School _____ High School _____ College _____ Graduate School
Current School: _____ Grade: _____
Marital Status: ___ Single ___ Married ___ Divorced ___ Separated ___ Widowed
Parent's Marital Status: ___ Single ___ Married ___ Divorced ___ Separated ___ Widowed
Parent's Occupation(s): _____
Sibling(s): Brother(s): _____ Sister(s): _____
Number of Children: _____

Medical History:

Height: _____ Weight: _____ Weight 1 year ago: _____
Usual Weight: _____ Lowest Weight: _____ Highest Weight: _____
Desired Weight: _____
Have you lost or gained weight recently? ___ Yes ___ No
Was this an intentional change? ___ Yes ___ No
Do you weigh yourself? ___ Yes ___ No How Often? _____
Are you concerned with your weight? ___ Yes ___ No

(For Children)
Birth Weight: _____ Breast fed? ___Yes ___No How long? _____
Mother's Height: _____ Father's Height: _____

Please indicate whether you or a family member have/had any of the following conditions:

Disease/Condition	Self	Family	Relationship	Treatment
Asthma	_____	_____	_____	_____
Cancer	_____	_____	_____	_____
Cardiovascular Disease	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____

Drug Dependency	_____	_____	_____	_____
Eating Disorder	_____	_____	_____	_____
Food Allergies	_____	_____	_____	_____
Food Intolerances	_____	_____	_____	_____
Kidney Disease	_____	_____	_____	_____
Headaches	_____	_____	_____	_____
Heart Attack	_____	_____	_____	_____
High Cholesterol	_____	_____	_____	_____
Hypertension	_____	_____	_____	_____
Intestinal Problems	_____	_____	_____	_____
Menstrual Problems	_____	_____	_____	_____
Mental Health Issues	_____	_____	_____	_____
Obesity	_____	_____	_____	_____
Osteoporosis	_____	_____	_____	_____

Other _____

Are you currently being treated for any medical conditions? ___ Yes ___ No
If yes, please specify: _____
Are you taking any medications? ___ Yes ___ No
Please list: _____

Are you taking any vitamin, mineral, food or herbal supplements? ___ Yes ___ No
Please list: _____

Have you ever been advised by your physician to follow a special diet? ___ Yes ___ No
What type? _____

Are you currently following that diet? ___ Yes ___ No
If not, indicate why; If yes, what changes have you made? _____

Do you drink alcohol? ___ Yes ___ No Number of drinks per week: _____
Do you smoke cigarettes? ___ Yes ___ No Amount per day: _____
How long have you smoked? _____ If you quit smoking, when? _____
Do you use drugs? ___ Yes ___ No Please explain: _____

Dieting History:

How many times have you tried to lose weight? _____
Age of first attempt: _____ Your weight at that time: _____
What diet did you follow? _____
Why did you go on that diet? _____

List other weight loss attempts:

Diet	Year	Outcome

Do you experience periods during which you eat uncontrollably? ___ Yes ___ No
If yes, how often? _____
At what age did this begin? _____
Have you ever been diagnosed with an eating disorder? ___ Yes ___ No
Please explain: _____
Are you currently or have you ever received treatment? ___ Yes ___ No
If yes, please explain: _____

Do you currently restrict food for weight control? ___ Yes ___ No
Please explain: _____
Do you currently exercise for weight control? ___ Yes ___ No
Please explain: _____

Exercise History:

Do you exercise? ___ Yes ___ No
List type, duration, frequency, and intensity of exercise activities: _____

Have you exercised in the past year? ___ Yes ___ No
List type, duration, frequency, and intensity of exercise activities: _____

Do you have any physical conditions that limit your ability to exercise? ___ Yes ___ No
Please specify: _____

Family Weight History:

Are any members of your family overweight? ___ Yes ___ No
Explain: _____
Are any members of your family underweight? ___ Yes ___ No
Explain:

Does anyone in your family diet? ___ Yes ___ No
Explain: _____
Did/Does anyone in your family have an eating disorder? ___ Yes ___ No
Explain: _____
Do you eat together? ___ Yes ___ No
What meals? _____

Eating Patterns:

How many days per week do you eat:

Breakfast:____ Lunch:____ Dinner:____

Do you snack? ___ Yes ___ No

When? _____

Do you buy or pack your lunches?

___ Buy # days per week:___ ___Pack # days per week:___

Do you eat out? ___ Yes ___ No

How many meals per week? _____

What restaurants do you usually choose?

1. 4. 7.

2. 5. 8.

3. 6. 9.

Who usually prepares the food at home? _____

Do you know how to cook? ___ Yes ___ No

Who does the grocery shopping? _____

Do you read food labels? ___ Yes ___ No What do you look at on the label? _____

Do the nutrition facts influence your decision to eat the food?	___ Yes	___ No
Do you eat standing up?	___ Yes	___ No
Do you eat in the car?	___ Yes	___ No
Do you eat while watching TV?	___ Yes	___ No
Do you eat while reading or on the computer?	___ Yes	___ No
Do you eat with others?	___ Yes	___ No
Do you eat fast?	___ Yes	___ No
Do you eat when bored?	___ Yes	___ No
Do you eat when stressed?	___ Yes	___ No
Do you eat when you are anxious?	___ Yes	___ No
Do you eat when you are lonely?	___ Yes	___ No
Do you eat when you are hungry?	___ Yes	___ No
Do you eat when you are not hungry?	___ Yes	___ No
Do you avoid certain foods?	___ Yes	___ No

Please specify: _____

What are your favorite foods? _____

Goals/Expectations

Do you want to change your eating habits? ___ Yes ___ No

Why? _____

Did you have any expectations from coming to see the nutritionist today? ___ Yes ___ No

Please explain:

Food Frequency Checklist

Patient's Name: _____ Date: _____

Check the Frequency the Following Foods are Consumed	Never or Less than Once per Week	1-2 Times per Week	3-7 Times per Week	More than Once a Day
Lean Beef				
High Fat Beef				
Sausage, Bacon, Lunchmeat				
Pork				
Poultry				
Poultry – Prebreaded, e.g. nuggets				
Poultry – Fried				
Fish				
Fish – Prebreaded, e.g. fish sticks				
Fish – Fried				
Shellfish				
Beans				
Peanut Butter				
Pizza				
Milk (Specify Type)				
Cream				
Cheese				
Cheese – Regular				
Cheese – Low Fat				
Cheese – Non-Fat				
Yogurt				
Ice Cream				
Frozen Yogurt				
Eggs				
Oils				
Butter				
Margarine				
Vegetables				
Fruits				
Fruit Juice				
Breads				
Cereals				
Pasta, Noodles, Rice, Etc. (cup)				
Potatoes				
Commercial Baked Goods (cookies, donuts, cakes, etc.) (Serving)				

Check the Frequency the Following Foods are Consumed	Never or Less than Once per Week	1-2 Times per Week	3-7 Times per Week	More than Once a Day
Cookies – Regular				
Cookies – Low Fat				
Cookies – Fat Free				
Soft Drinks (Non-Diet) (Serving)				
Snack Crackers (Serving)				
Nuts and Seeds (1/4 Cup)				
Potato Chips or Corn Chips (Cup)				
Sherbets and Ices (1/2 Cup)				
Candy				
Frozen Meals				
Chinese Food				
Fast Food				