NUTRITION EDUCATION INTAKE FORM

WELL-BEING & HEALTH PROMOTION

Name _____ Date of Birth _____ Date _____

Red ID _____

Height _____ Weight _____ Phone _____

Allergies? _____

Were you referred, if yes, by whom? _____

Year in School _____

Clubs or Organizations you are involved in _____

STUDENT STATUS

- ☐ Part-time undergraduate
- ☐ Full-time undergraduate
- ☐ Part-time graduate
- ☐ Full-time graduate
- ☐ None of the above

WHAT IS YOUR EMPLOYMENT STATUS?

- ☐ Work full-time
- ☐ Work part-time
- ☐ Unemployed
- ☐ Other _____
- ☐ How many hours a week do you work? _____

WHICH OF THE FOLLOWING BEST DESCRIBES YOUR CURRENT LIVING SITUATION?

- ☐ Live on campus in residential hall or apartment
- ☐ Live off campus by myself, with roommate(s), or significant other
- ☐ Live with parents or guardian
- ☐ Live in a fraternity or sorority house
- ☐ Other _____

PLEASE INDICATE WHAT TOPICS ARE PRIORITIES FOR THE DIETITIAN TO DISCUSS?

- ☐ Weight loss
- ☐ Weight gain
- ☐ Exercise
- ☐ Lower fat/lower sodium diet
- ☐ General nutrition information
- ☐ Other _____

Nutritional Status

Recent weight loss greater than 5 pounds within 30 days ☐ No | ☐ Yes _____

Are you currently on a weight reduction diet? ☐ No | ☐ Yes _____

Have you had a recent change in appetite? ☐ No | ☐ Yes _____

Do you have any problems with swallowing? ☐ No | ☐ Yes _____

Do you have any problems with chewing? ☐ No | ☐ Yes _____

Do you have any problems with sore mouth? ☐ No | ☐ Yes _____

Do you have any problems with nausea? ☐ No | ☐ Yes _____

Do you have any problems with diarrhea? ☐ No | ☐ Yes _____

Do you have any problems with vomiting? ☐ No | ☐ Yes _____

Do you have any problems with constipation? ☐ No | ☐ Yes _____

Have you had a recent weight change within the last 6 months? ☐ No | ☐ Yes _____

Are you on any medications? (If yes, please list them) ☐ No | ☐ Yes _____

Are you on any dietary supplements? (If yes, please list them) ☐ No | ☐ Yes _____

Dietary History

Name some foods that you seldom/never eat and why (religion, lifestyle, allergy, etc.):

Who prepares your meals? _____

Are you currently on a special diet? (If yes, what kind) ☐ No | ☐ Yes

Are you on any dietary supplements? (If yes, please list below) ☐ No | ☐ Yes

Have you ever had a history of an eating disorder, purging, or binge eating? (If yes, please explain) ☐ No | ☐ Yes

Do you currently suffer from disordered eating or an eating disorder? (If yes, please explain) ☐ No | ☐ Yes

Are you satisfied with your eating patterns? (If no, why?) ☐ No | ☐ Yes

Do you ever eat in secret? ☐ No | ☐ Yes

Does your weight affect the way you feel about yourself? ☐ No | ☐ Yes

Have any members of your family suffered from an eating disorder? (If yes, whom?) ☐ No | ☐ Yes

On a scale from 1 to 10 (1 = no desire at all and 10 = strongly desire), please rate the following by circling a number:

How important is it that you change your diet or behavior (lifestyle) to meet your goals?

1 2 3 4 5 6 7 8 9 10

How confident are you that you can make the desired changes to meet your goals?

1 2 3 4 5 6 7 8 9 10

Medical History/Physical Activity

When was the last time you saw a medical provider (MD, RN, etc.)?

Do you have a history of medical issues? (If yes, please explain) ☐ No | ☐ Yes

On average, how many days do you take part in exercise for at least 20 minutes that makes you sweat and breathe hard? (e.g. basketball, jogging, fast dancing, swimming laps, tennis, fast bicycling, or similar aerobic activities)

1 2 3 4 5 6 7

How many hours of sleep do you get each night, on average? _____

Do you currently smoke cigarettes or chew tobacco? ☐ No | ☐ Yes

Do you consume alcoholic beverages? ☐ No | ☐ Yes

If yes, how many beverages do you consume per day, on average? _____

Do you binge drink? *(Definition: Men - >5 drinks; Women - >4 drinks in a 2 hour period)* ☐ No | ☐ Yes

Are you an occasional drinker (birthdays, holidays, etc.)? ☐ No | ☐ Yes

Is there anything else you would like to discuss?