Nutrition Intake

Date: _____

Please complete the following information:

Name: _____
Phone: _____ May a message be left on your voice mail? _____
Do you live on or off campus?: _____
Age: _____ Year in school: _____ Major: _____
Referred by: _____

Medical History

Height: _____ Weight: _____
Do you utilize the student health center or see an off campus physician for medical concerns:
_____
Do you have any medical conditions?
_____
Are you currently taking any medications (please list prescribed and/or over the counter such as aspirin, laxatives, diet pills)
_____
Are you taking any supplemental vitamins, minerals, or herbs?
_____

Please indicate any medical/psychological conditions you have ever had or presently have by placing an (x) in the blank:

_____ Heart disease	_____ High cholesterol	_____ Diabetes
_____ Depression	_____ Eating Disorder	_____ Food allergies/intolerances
_____ High Blood Pressure	_____ Obesity/overweight	_____ Gastrointestinal problems
_____ Constipation/diarrhea	_____ Alcohol/drug abuse	_____ Other

Does anyone in your family have any of the above medical problems? If yes, please list family member and problem:
_____

For females only:
Do you have irregular periods? _____
If yes, date of last menstrual cycle: _____
Are you currently taking oral contraceptives or any other hormones?
_____

Please continue on the back

Lifestyle Profile

Do you currently smoke? _____
Do you consume alcohol regularly (at least once/week) _____

Do you currently exercise? _____ Type and frequency: _____

How stressful do you consider your life right now? (circle) 1 2 3 4 5
1 not stressful/5 extremely stressful

How is your food intake affected by stress (check all that apply):
_____ No effect _____ Eat more _____ Eat less
_____ Gastrointestinal problems _____ other

Nutrition Profile

Have you consulted a nutritionist before, if yes for what purpose: _____
Have you lost or gained more than 10 pounds in the past year? _____
Please place an (x) in front of the statements which describe your eating pattern:
_____ Eat three meals a day _____ Often skip meals _____ Snack between meals
_____ Often eat out _____ Often eat "on the go" _____ Often eat in car
_____ Follow Vegetarian diet_____ Avoid specific foods _____ Frequently diet
_____ Currently follow special diet
_____ Use calorie restriction to lose weight
_____ Use other means to lose weight (laxatives, diet pills, etc.)
_____ Get rid of food after eating (laxatives, vomiting, exercise)

Where do you eat/prepare most of your meals? _____
Do you purchase foods at the grocery store? _____
Do you read food labels? _____ What do you look for on labels? _____

Please list the reason(s) you are here today and any questions you have:

_____

_____

Thank You!