Lifestyle Questionnaire – Nutrition History

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Name_____ Date of visit_____
Address_____ Email_____
_____
Home Phone_____ Cell_____ Work_____
Preferred method of communication_____
How did you hear about The Center for Mind Body Nutrition? (Check what applies)
Online Search____ Social Media____ Medical Provider Referral____
Friend referral ____ Other_____

Have you ever wanted to make changes in what you eat? Yes___ No___
If yes what advice have you been given? _____
Are You following any type of meal plan, such as exchange lists, calorie counting, carbohydrate counting, low carb, low sodium, gluten free? Yes__ No__
If yes, please describe_____
If yes, how much of the time are you following your meal plan?
Rarely__ Sometimes__ Often__ Usually__
Which of these methods have you tried to manage your weight? (gain or lose)?

	Check all that apply		Did it work Y/N
A. Dietitian/Nutritionist	Y____	N____	_____
B. Exercise	Y____	N____	_____
C. Low calorie diet	Y____	N____	_____
D. Very-low-calorie-diet (i.e., liquid, HMR, protein sparing, Medifast)	Y____	N____	_____
E. Formal group diet program (i.e., Weight Watchers, OA)	Y____	N____	_____
F. Prescription diet drugs (Please list) _____	Y____	N____	_____
G. Over-the-counter diet drugs (e.g. Alli, Hoodia)	Y____	N____	_____
H. Psychological counseling / behavior modification	Y____	N____	_____
I. Hypnosis	Y____	N____	_____
J. Have you ever induced vomiting or used laxatives for weight loss?	Y____	N____	_____
K. Have you ever engaged in excessive exercise to help you lose weight?	Y____	N____	_____

If you did not maintain your weight change for at least one year, why do you think you were not successful?
_____
_____

Do family members struggle with being overweight? (*Circle those that apply*) Father Mother Brother(s) Sister(s)
Do they have a history of eating disorders (anorexia, bulimia, binge eating, compulsive overeating?) Y___ N___

Do you…

Eat differently when you are alone?	Y____	N____
Eat when you are upset or nervous?	Y____	N____
Eat sweets or salty snacks?	Y____	N____
Tend to binge eat?	Y____	N____
Eat in front of the TV or computer?	Y____	N____
Eat meals or snacks in the car?	Y____	N____
Are you comfortable with the way you eat?	Y____	N____
Do you ever feel shame or guilt after eating?	Y____	N____
What percentage of time do you think about food, eating, and exercise?	_____%	
How do you feel when you see your body? 1 2 3 4 5 (Extreme dislike / Neutral / Extreme like)		
Do you have trigger foods that cause you to overeat?	Y____	N____
Do you now or have you in the past eaten for reasons other than hunger?	Y____	N____

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Medical History:

Check all medical conditions that apply to you.

A.	Diabetes mellitus 1 or 2	Y____	N____
	Pre-Diabetes	Y____	N____
B.	High blood pressure	Y____	N____
C.	High cholesterol	Y____	N____
D.	Low back pain	Y____	N____
E.	Arthritis/joint pain	Y____	N____
F.	Sleep apnea	Y____	N____
G.	Asthma	Y____	N____
H.	Heartburn (GERD)	Y____	N____
I.	Gallbladder/gallstones	Y____	N____
J.	Liver disease	Y____	N____
K.	Kidney disease	Y____	N____
L.	History of cancer	Y____	N____
	If yes specify_____		
M.	Thyroid	Y____	N____
N.	Menopause	Y____	N____
O.	Surgery: _____		
	_____		
P.	Pregnancy	Y____	N____
Q.	Digestive health issues (circle) (IBS, stomach ulcers, ulcerative Colitis, Crohn's disease)	Y____	N____

Please list vitamin and herbal products.

_____
_____
_____

Please list all allergies or intolerances (i.e., lactose, gluten)

_____
_____
_____
_____

Eating patterns:

Please pick the number that best describes how much these behaviors may influence your weight.

1 = Does not contribute
2 = Contributes a small amount
3 = Contributes a small amount
4 = Contributes a large amount
5 = Contributes the greatest amount

_____A. Eating too much food
_____B. Not eating enough food
_____C. Overeating during the day
_____D. Overeating at night
_____E. Snacking between meals
_____F. Binge and purge
_____G. Eat because I am hungry
_____H. Eating because I have cravings
_____I. Cannot stop once I am full
_____J. Eating because it tastes good
_____K. Eating because I am not full
_____L. Eating because it smells or looks good
_____M. Eating while cooking/ preparing meals
_____N. Eating when anxious
_____O. Eating when tired
_____P. Eating when bored
_____Q. Eating when stressed
_____R. Eating when angry
_____S. Eating when depressed/ upset
_____T. Eating when socializing
_____U. Eating when happy
_____V. Eating when alone
_____W. Restricting food

Any other factors you feel may have contributed to your weight change.

_____
_____
_____

Please list all present prescription medications/doses:

_____
_____
_____
_____
_____

Meal	Days per week	Time
Breakfast		
Morning snack		
Lunch		
Afternoon snack		
Dinner		
Nighttime snack		

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Who prepares meals at home? _____ Who meal plans?_____

Who Grocery shops? _____

Describe your appetite:

___Strong, must eat when hungry. ___Variable, sometimes hungry or not; forget to eat if busy

___Not hungry a lot; OK if I eat once or twice a day.

Do you smoke? Y____ N____ Quantity? _____

If you quit, for how long? _____

How many hours of sleep do you get each night?

_____

Do you have difficulty sleeping? Explain_____

Please list any supplements, (amt., and brand) you are currently taking: (i.e. calcium, fish oil, vit D multivitamin, etc)_____
_____

<u>Gastrointestinal symptoms:</u> On a scale of 1-10(10 = terrible, 0 = non-existent), please state a number to identify the intensity of the symptoms:

Gas_____

Bloating_____

Nausea_____

Diarrhea_____

Constipation_____

Abdominal Pain_____

Reflux / GERD_____

System Symptoms

Skin Itch _____

Uticaria (hives) _____

Fatigue_____

Insomnia/Sleep Disturbance_____

Anxiety_____

Have you experienced any significant life changes (marriage, divorce, death of a family member, new home, change in employment in the last year? Y N How has this affected your stress level? _____
_____
_____
_____

How do you deal with stress and how does stress affect you physically and emotionally?
_____
_____
_____

Do you feel you are ready to make changes in your life? Y N

How confident are you that you can make the necessary changes to improve your health? Pick a number from 1-10, 1= “not at all”, 10 = “extremely confident” _____

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Please check the frequency of these foods that you eat regularly. Circle those foods you frequent most.

Fruit: apples, pears, peaches, bananas, grapes, raspberries, strawberries, cherries, blueberries, melons oranges, pineapple	Daily	2-3x per week	1x per week	1x per month	Rare or Never
Vegetables: salad, dark greens, carrots, tomatoes, peppers cucumber, onions, squash, zucchini, eggplant, broccoli, cauliflower, cabbage					
Protein foods: red meat, chicken, white fish, fatty fish, tuna, eggs, lunch meat, turkey, dried beans and peas, peanut butter, tofu, nuts					
Dairy: skim milk, 1% milk, 2% milk, yogurt, ice cream, pudding, cottage cheese, hard cheese					
Snacks: Chips, crackers, pretzels, popcorn, trail mix					
Sugary foods: iced tea, soda, donuts, pastry, cake, cookies, candy, cupcakes, pies					
Grains: white rice, white bread, biscuits, bagels, muffins					
Whole Grains: whole wheat bread, brown rice, whole grain cereal,					
Fast food					
Alcohol					

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24 hour food recall: Please write down all the foods and drinks you consumed yesterday.

Meal	**Time**	**Food/drink (include how prepared)**	**Amount**	**Where did you eat this?**
Morning meal				
Snack				
Midday snack				
Snack				
Evening Meal				
Snack/ Dessert				

Please name the three most important nutrition/lifestyle goals you would like to achieve?

1._____

2._____

3._____

Would you like to learn techniques to decrease stress? Yes_____ No_____

Have you ever participated in any meditation techniques to decrease stress? Yes_____ No_____

NUTRITION COUNSELING AND CLIENT AGREEMENT

Our Responsibilities: Our work is in partnership with each other and we both have responsibilities. As your registered dietitian/nutrition therapist, I will provide medical nutrition therapy and counseling to you and will be on time for our appointments. All information you share with me will be kept in strict confidence unless I have an explicit agreement from you that states otherwise. You can expect my honest evaluation and professional skills in recommendations for your success and I will acknowledge your progress with you. I will honestly advise you on areas you may need to improve upon. You will agree to be on time for appointments and prepared for the appointment. I ask that you respect the payment schedule and cancellation policy we have arranged.

Missed Appointments: Arriving on time offers you a full professional session; arriving late means your session will be shortened to accommodate the needs of others who have appointments following yours. As unplanned issues may arise that lead you reschedule your appointment***, 4 hours notice is needed in advance of your appointment***; *if less than 4 hours notice***, you will be charged in full for that scheduled time**. If there is availability within a week for you to make up the missed appointment, there will be no charge.

Private Pay:	Initial Consultation:	$110	60-75 minutes
	Follow-up:	$65	45 minutes
		$45	30 minutes

Insurance Plans accepted:

Highmark BC/BS

Please call your insurance company and ask if nutrition counseling is a covered service. You will need to find out if your diagnosis is covered, if a doctor referral is needed and if there are any co-pays or deductibles that need to be met. If there is insufficient coverage, you will be responsible for the consultation fee.

Thank you for choosing The Center for Mind Body Nutrition.

Your Signature Here indicates:

_____You have been informed of and understand the payment policy of The Center for Mind Body Nutrition

_____
Print Name

_____
Sign Name