Nutrition Works Client Health History

Name:	**Birth Date:**	**Age:**	**Today's Date:**

List your main health concerns in order of importance:	**Duration of problem:**
1.	
2.	
3.	

What are you hoping to get out of your visit(s) with the dietitian?

Circle or write in your past or present medical conditions and/or symptoms:

Heart attack/stroke/CABG	Diabetes	Pre-diabetes
High blood pressure	High cholesterol	High triglycerides
Gastric reflux (GERD)	Osteopenia/osteoporosis	Gallstones
Kidney stones	Kidney disease	Hypothyroidism
PCOS	Cancer	Anemia
Vitamin deficiency	Anxiety/depression	Eating disorder
Diarrhea	Constipation	Irritable bowel syndrome (IBS)
Lactose intolerance	Crohn's/Ulcerative Colitis	Food allergy/sensitivity
Migraine headaches	Autism	Celiac disease

Other:

Significant family history?

Weight history:

Height:	Current Weight:	Most Weight:
Lowest weight in past **5** years:	Lowest weight past in past **10** years:	
Recent weight loss or gain? Yes No	How much? Over what time period?	Was recent loss/gain intentional? Yes No
Your preferred weight:	Are you looking for assistance with weight management? Yes No	

If yes, what approach has worked well for you in the past?

Please list all prescription or over-the counter medications, supplements and herbal preparations:

Name:	Dose:	Start Date:		Name	Dose:	Start Date:

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Exercise	
How often do you exercise? Never Rarely Occasionally Frequently Every Day	
What type of exercise do you do?	How many minutes/hours per week (total)?
How long have you followed your current exercise routine?	Do you have any concerns about whether it is safe for you to exercise? Yes No
What factors, if any, limit your ability to exercise?	How long has it been since your last check-up with your physician?

Health and social habits:	
What are your living arrangements:	Who does the shopping and cooking at home?
How are your cooking skills? good fair poor	Do you bring lunch to work? Yes No Sometimes
Number of times per week you eat food from a restaurant, fast-food, cafeteria or take-out? Include snacks, breakfast, lunch and dinner:	Where?
Do you smoke? Yes No Quit _____ years ago	Do you salt your food? Yes No
Do you drink coffee or tea? Yes No How much? How do you take it?	Do you drink alcoholic beverages? Yes No What and how much?
Do you drink soda? Yes No What kind and how much?	Do you have any concerns about disordered eating thoughts or behaviors? Yes No
How many times a day do you eat?	Do you eat during the night?

<u>If you are seeking assistance with weight management</u>, please circle your problem areas:			
Eat too much (portions)	Drink too much	Daytime snacking	Nighttime snacking
Poor food choices	Skipping meals	Bingeing	Frequent Travel
Boredom	Stress	Quit smoking	Cost of food
Don't know how to cook	Eating out	Food cravings	Don't like exercise
Don't like to cook	Long commute	Long work hours	No time to exercise
Healthy foods bother my health condition	My diet conflicts with others in family	My health conditions call for conflicting diets	Can't exercise due to my health condition
Socializing	Don't like vegetables	Don't know what to eat	Food sensitivies
History of "failed" diets	Feel out of control	Not ready for change	Not sure

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