Ashvini Mashru

REGISTERED DIETITIAN NUTRITIONIST

LIFESTYLE TRANSFORMATION THROUGH FOOD

Dietitian History/New Client Questionnaire and Assessment

General Information:

Name: ______________________________ Today's Date: ____________

Occupation: ______________________________ ___ Full time ___ Part time

Place of Employment: ______________________________

Address: ______________________________

Phone: ____________ Phone #2: ____________ Email: ____________

Age: ________ Date of Birth: ____________ Gender: ________

Reason for Appointment: ______________________________

____

____

____

Primary Care Provider: ______________________________

____

Address/Phone: ______________________________

____

Therapist: ______________________________

____

Address/Phone: ______________________________

____

Education level: ____Grammar School ____ High School ____ College ____ Graduate School

Marital Status: ___ Single ___ Married ___ Divorced ___ Separated ___ Widowed

Number of Children: ______________________________

Age: ________ Date of Birth: ____________ Gender: ____________

Age: ________ Date of Birth: ____________ Gender: ____________

Age: ________ Date of Birth: ____________ Gender: ____________

Age: ________ Date of Birth: ____________ Gender: ____________

Age: ________ Date of Birth: ____________ Gender: ____________

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

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: ____

List any medications you are currently taking or have taken in the last year:

1. ______________________ 2. ______________________

3. ______________________ 4. ______________________

5. ______________________ 6. ______________________

7. ______________________ 8. ______________________

9. ______________________ 10. ______________________

Are you currently taking any food or nutritional/herbal supplements? ___ Yes ___ No

If yes, please specify: ____

Have you ever been advised by your physician to follow a special diet? ___ Yes ___ No
If yes, please specify: ______

Are you currently following that diet? ___ Yes ___ No
If not, 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 Explain: ______

Menstrual History: (Female Patient):
Are you currently menstruating? ___ Yes ___ No _____Have never menstruated
At what age did you get your first period? ______
Date of last menstrual cycle: ______ Weight at that time: _____ pounds
Are your periods regular? ___ Yes ___ No
Are you taking birth control pills / estrogen pills? ___ Yes ___ No
Do you experience PMS? ___ Yes ___ No
If yes, what are your symptoms? ______

Weight/Dieting History:
Have you tried to lose weight before? ___ Yes ___ No
How many times? ______ Age of first attempt: _____ years
What did you do? ______
Why did you go on that diet? ______

Have you ever used any of the following for weight control? If yes, please explain.
Commercial diet programs _____ Yes _____ No ______
Liquid diets _____ Yes _____ No ______
Fad diets _____ Yes _____ No ______
Prescription diet pills _____ Yes _____ No ______
Over-the-counter diet pills _____ Yes _____ No ______
Laxatives _____ Yes _____ No ______
Diuretics _____ Yes _____ No ______
Ipecac syrup _____ Yes _____ No ______
Vomiting _____ Yes _____ No ______
Self-designed program _____ Yes _____ No ______
Other ______
Do you experience periods during which you eat uncontrollably? ___ Yes ___ No
If yes, how often? ______

At what age did this begin? _______ years
Is this followed by:

_____ Vomiting Age began:_______ How often? ________________________________
_____ Laxative use Age began:_______ How often? ________________________________
_____ Excessive exercising Age began:_______ How often? ________________________________
_____ Self harm Age began:_______ How often? ________________________________
_____ Negative emotions Age began:_______ How often? ________________________________
_____ Other (explain) ____

Have you ever been diagnosed with an eating disorder? ___ Yes ___ No
If yes, please explain: ____
Are you currently or have you ever received treatment? ___ Yes ___ No
If yes, please explain: ____
____
Do you currently exercise for weight control? ___ Yes ___ No
Please explain: ____

Exercise History:

Do you exercise? ___ Yes ___ No
Please explain: ____

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
Please explain: ____
Are any members of your family underweight? ___ Yes ___ No
Please explain: ____
Does anyone in your family diet? ___ Yes ___ No
Please explain: ____
Did/Does anyone in your family have an eating disorder? ___ Yes ___ No
Please explain: ____
Does your family eat meals together? ___ Yes ___ No
What meals? ____
What is this like? ____

Eating Habits:

Do you skip meals? ___ Yes ___ No
How many days per week do you eat:
Breakfast: _____ Lunch:_____ Dinner:_____
Do you snack? ___ Yes ___ No
If so, 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

If yes, please specify: ______________________________

What are your favorite foods? ______________________________

____

Malnutrition Symptoms:

Do you now or have you ever experienced (for each checked, please add details to explain):

_____ Irregular menstrual periods ______________________________

_____ Absent menstrual periods ______________________________

_____ Cold intolerance ______________________________

_____ Tingling sensation in hands or feet ______________________________

_____ Headaches ______________________________

_____ Lightheadedness/Dizziness ______________________________

_____ Fainting ______________________________

_____ Sleeping difficulties ______________________________

_____ Skin changes ______________________________

_____ Hair loss ______________________________

_____ Hair growth on face and/or chest ______________________________

_____ Chest pains ______________________________

_____ Rapid heart beat ______________________________

_____ Shortness of breath ______________________________

Mood swings

_____ ______________________________

_____ Episodes of crying for "no reason" ______________________________

_____ Frequently thinking about food ______________________________

_____ Confusion ______________________________

_____ Difficulty concentrating ______________________________

_____ Anxiety, especially around food ______________________________

_____ Less social interaction with family ______________________________

_____ Frequently tired ______________________________

_____ Memory problems ______________________________

_____ Difficulty making decisions ______________________________

_____ Problems with teeth ______________________________

_____ Sore throat ______________________________

_____ Swollen parotid glands ______________________________

_____ Taste changes ______________________________

_____ Constipation ______________________________

_____ Diarrhea ______________________________

_____ Muscle pain ______________________________

_____ Joint pain ______________________________

_____ Obsessive-compulsive behaviors ______________________________

_____ Feelings of depression ______________________________

_____ Other (explain) ______________________________

Goals/Expectations

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

Why? ______________________________

____

Did you have any expectations from coming to see the dietitian today? ____ Yes ____ No

Please explain: ______________________________

Food Frequency Checklist

Client'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
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				

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
Breads				
Cereals				
Pasta, Noodles, Rice, Etc. (cup)				
Potatoes				
Commercial Baked Goods (cookies, donuts, cakes, etc.) (Serving)				
Cookies				
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				