NUTRITION AND MEDICAL QUESTIONNAIRE
INITIAL ASSESSMENT AND INTERVIEW

To be filled out by client or Guardian:	Reserved for Dietitian notes
Name_________________________ Date______________ Sex_____ Age_______ Date of Birth________________ Address____ City____ Home phone________________ Work phone___________	
Primary Physician__________________________________ Insurance ____ Policy number_____________________________________ Reason for seeing dietitian__________________________ How long have you had this condition?________________	
Personal Medical History: Check conditions you have had __Heart disease or stroke __Diabetes __Diarrhea __Gastrointestinal problems __Constipation __High blood pressure __High cholesterol __Arthritis __Cancer __Anemia __Lung problems/asthma __Chewing problems __Overweight/obesity __Ulcer __Gallbladder disorder __Allergies Family Medical History: Check conditions that any blood relatives have had __Heart disease or stroke __Diabetes __Diarrhea __Gastrointestinal problems __Constipation __High blood pressure __High cholesterol __Arthritis __Cancer __Anemia __Lung problems/asthma __Chewing problems __Overweight/obesity __Ulcer __Gallbladder disorder __Allergies How has your life been affected by your medical conditions?___________________________________ Page 1	

To be filled out by client:	Reserved for dietitian notes:
Marital Status: __Single __Married __Divorce/Separated __Widowed Last grade completed:____ Occupation______________ List people in household: Name Relationship Age	
Anyone else in the household on a special diet? What type? Who cooks for you? How often do you eat out each week? Where you eat out What you eat:	
List any food you are allergic to: Food dislikes or intolerances:	
Height:_____________ Current weight__________ Usual weight________ Goal weight____________ Pounds lost in 12 months_____ Pounds gained _______ Are you on or have you been on a special diet?________ What type? How long did you stay on your meal plan?____________ List any vitamin or health supplements you are taking: Page 2	

To be filled out by client:	Reserved for dietitian notes:
List all medications you are taking Alcohol Intake: Tobacco Intake: How much Quit recently?	
Exercise Regularly? What type? How many times per week? Duration of exercise (minutes/hours) Any problems or physical Iimitations to exercise?	
Self Assessment of stress level: ___ High ______Medium _____ low Any stressful life events recently?	
What are your goals? What help would you like from the dietitian?	

I have given this information to the best if my knowledge. My signature below gives permission for the Center for Well-Being to exchange necessary medical and related information with my physician, health plan, medical group, therapist and/or other health or social services providers involved in my care. I acknowledge that I have received a copy of the Center's Notice of Privacy Practices.

Clients signature____Date____________

FOOD INTAKE RECORD

MEAL	AMOUNT AND TYPE OF FOOD AND DRINK	CALCULATIONS FOR RD
Breakfast		
Snack		
Lunch		
Snack		
Dinner		
Snack		