Name: _____ Birth Date: _____ Today's Date: _____

How did you hear about Sheri Barke's nutrition counseling services?

- ☐ Health/Fitness Professional: _____ ☐ Web Site: _____
- ☐ Friend or Family Member: _____ ☐ Other: _____

What are your specific nutrition concerns and goal(s) for this nutrition consultation?

_____
_____
_____

NUTRITION ASSESSMENT

MEDICAL HISTORY:

Have you, or anyone in your immediate family, had any of the following conditions?

			Explanation: relationship / age at diagnosis
high blood cholesterol	Yes	No	_____
high blood pressure	Yes	No	_____
heart attack and / or stroke	Yes	No	_____
cancer	Yes	No	_____
obesity / overweight	Yes	No	_____
diabetes	Yes	No	_____
alcohol and / or drug abuse	Yes	No	_____
eating disorder*(see page 4)	Yes	No	_____
depression / mood problems	Yes	No	_____
gastrointestinal problems	Yes	No	_____
Please circle type(s): reflux/heart burn, gas, constipation, diarrhea, irritable bowel syndrome, other_____			
osteoporosis	Yes	No	_____
other _____	Yes	No	_____

If applicable, please list results from any recent, relevant medical tests/procedures (i.e. blood work):

_____
_____

Are you taking any medications, including birth control and over-the-counter drugs (such as aspirin, antacids, diet pills, laxatives, etc.)? Yes No

If yes, please identify. _____
_____

Are you taking any dietary supplements (i.e. vitamins, minerals, herbs, protein powders, pre/post workout products, weight gainers, etc.)? Yes No

If yes, please identify. _____
_____

Do you have any food allergies or food intolerances? Yes No

If yes, please identify. _____

The following questions apply to females only:

Age of menarche: _____ Have you ever had irregular periods? Yes No
Age of menopause: _____ If yes, please describe: _____

WEIGHT HISTORY:

(To be completed by dietitian) BMI =
IBW =

Present height? _____ Present weight? _____

Have you had a recent (within past 6 mos.) change in weight? Yes No

If yes, please explain: _____

_____

_____

What has been your highest weight? _____ Age?_____ Your lowest weight?_____ Age? _____

How would you evaluate your present weight? underweight about right overweight

Are you concerned about your weight or body shape/size? Yes No

If so, at what age did your weight/body concerns begin? _____

What percent of your day is spent thinking/worrying about your weight/body? _____

How often do you weigh or measure yourself? _____

Have you ever tried to lose (or gain) weight before? Yes No

If yes, which methods have you tried?_____

_____

What is your desired weight? _____ Last time you weighed this? _____ For how long? _____

LIFESTYLE PROFILE:

Current living situation *(circle one)*: live alone live with family live with friend/partner/roommate

How stressful do you consider your life right now?

1 2 3 4 5

not stressful at all----------*extremely stressful*

What are your primary sources of stress? _____

How is your food intake/tolerance affected by stress? *Please circle all that apply.*

No effect Eat more Eat less Eat different types of food Irritable bowel (diarrhea, constipation, gas, etc.)

Do you currently exercise? Yes No

If yes, what do you do and how much? _____

_____

How often do you have a drink containing alcohol? _____

When you drink, <u>what</u> and <u>how much</u> do you typically consume? _____

In the past year, have you been unable to remember what happened due to drinking? Yes No

Do you use tobacco, marijuana, or other drugs? Yes No

If yes, what do you use, how much, how often? _____

How many hours of sleep do you typically get each day/night? _____

Do you have any sleep concerns*? (i.e.* difficulty falling and/or staying asleep, sleep walking/eating, etc.)

Yes No If yes, please describe: _____

TYPICAL EATING PATTERN:

Are you following a special diet or eating plan at this time (i.e. vegetarian, Paleo, Weight Watchers, etc.)?

Yes No If yes, please describe: _____

Are there any foods that you avoid? _____

Please list your typical daily food/beverage intake below. NOTE: If you have two distinctive patterns (i.e. "good days" and "bad days"), please describe each pattern separately.

Time *Food/Beverage* *Location*

How much of the following beverages do you drink each day? (please specify cups, ounces, cans, etc.)

Water	_____	Soda (regular or diet)	_____
Coffee	_____	Energy drink	_____
Tea	_____	Sports drink or "Fitness Water"	_____
100% Fruit juice	_____	Milk (check one)	_____
Sweetened fruit drink (punch, lemonade, etc.)	_____	☐ fat free ☐ 1% low fat ☐ 2% reduced fat ☐ whole ☐ soy/rice/almond milk_____	

DISORDERED BEHAVIORS *(If applicable):*

Which behaviors do you (or have you ever) engaged in? Place an astrixt (*) next to current behaviors.

_____ Count calories How many calories (or points) do you eat per day? _____

_____ Count macronutrients (carbs, fats, protein) Which one(s) and how many grams of each per day _____ _____

_____ Feel extreme guilt, shame, and/or panic about eating certain foods or quantities of food
How many times per day, week, or month? _____

_____ Feel extreme guilt, shame, and/or panic about missing exercise sessions

_____ Intentionally skip meals or avoid eating How many times per day, week, or month? _____

_____ Binge (i.e. uncontrollably eat a very large amount of food in a short period of time)
How many times per day, week, or month? _____

_____ Eat for emotional reasons when not physically hungry
How many times per day, week, or month? _____

_____ Vomit after eating How many times per day, week, or month? _____

_____ Spit food out after eating How many times per day, week, or month? _____

_____ Exercise excessively after eating How many times per day, week, or month? _____

_____ Use laxatives/diuretics How many used per day, week, or month? _____

_____ Use "body shaping" dietary supplements or drugs (i.e. diet pills, stimulant drugs, caffeine products, steroids, pro-hormones, most "fat burners" and "body building" supplements)
Specify what and amount used per day, week, or month: _____

_____ Chew gum excessively How many pieces per day, week, or month? _____

Comments *(To be completed by dietitian)*

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____