



One's health and well-being are influenced by many different things, including lifestyle family history, emotional health, and nutrition/eating habits. Please complete the following questionnaire to the best of your ability to give us an overall view of your general lifestyle and health habits.

New Patient Nutrition Assessment Form

First Name: _____ Middle Name: _____ Surname: _____

Address: _____

_____ Postal Code: _____

Please indicate your preferred method of contact: Home work cell email

Home Phone _____

Birth Date ____/____/____ Age _____

Work Phone _____

Email address: _____

Cell Phone _____

Height ____' ____ Sex _____

Blood Type (Please circle): A/AB/B/O/Unknown

Occupation _____

Marital Status _____

Do you have children? Yes No

Age of children _____

Are you pregnant? Yes No Due date _____

With whom do you live? (Include children, parents, relatives, and/or friends. (Please include ages.)

Example: Sarah, age 7, sister

Primary Care Provider _____ Date of last physical exam _____

Other doctors or practitioners you see _____

Would you like to receive e-mail notifications regarding cooking classes/demonstrations?

If yes, please sign _____

GOALS AND READINESS ASSESSMENT

I would like to visit with a nutritionist, today because...

My food and nutrition-related goals are...

My overall health goals are...

If I could change three things about my health and nutritional habits, they would be...

1.

2.

3.

The biggest challenge(s) to reaching my nutrition goals is/are:

In the past, I have tried the following techniques, diets, behaviours, etc. to reach my nutrition goals...

On a scale of 1 (not willing) to 5 (very willing), please indicate your readiness/willingness to do the following:

To improve your health, how ready/willing are you to...	1	2	3	4	5
Significantly modify your diet					
Take nutritional supplements each day					
Keep a record of everything you eat each day					
Modify your lifestyle (ex: work demands, sleep habits, physical activity)					
Practice relaxation techniques					
Engage in regular exercise/physical activity					
Have periodic lab tests to assess your progress					

PAST MEDICAL AND SURGICAL HISTORY

Please indicate whether you or your relatives have been diagnosed with any of the following diseases or symptoms (specify which relative and the date of diagnosis).

Illness/Disease/Symptom	Self: Age Diagnosed	Relative: Age Diagnosed	Describe/Specify
<input type="radio"/> Allergies (Please specify type)			
<input type="radio"/> Anemia			
<input type="radio"/> Anxiety or Panic Attacks			
<input type="radio"/> Arthritis (osteoarthritis or rheumatoid)			
<input type="radio"/> Asthma			
<input type="radio"/> Autoimmune conditions (please specify)			
<input type="radio"/> Bronchitis			
<input type="radio"/> Cancer			
<input type="radio"/> Chronic Fatigue Syndrome			
<input type="radio"/> Chrons Disease or Ulcerative Colitis			
<input type="radio"/> Depression			
<input type="radio"/> Diabetes (Specify type 1/2 , Prediabetes, Gestational Diabetes)			
<input type="radio"/> Dry, itchy skin, rashes, dermatitis			
<input type="radio"/> Eczema			
<input type="radio"/> Emphysema			

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<input type="radio"/> Epilepsy, convulsions, seizures			
<input type="radio"/> Eye disease (please specify)			
<input type="radio"/> Fibromyalgia			
<input type="radio"/> Food Allergies or Sensitivities			
<input type="radio"/> Fungal Infection (athletes foot, Ringworm, other)			
<input type="radio"/> Gallbladder Disease/Gallstones (specify)			
<input type="radio"/> Gout			
<input type="radio"/> Heart attack / Angina			
<input type="radio"/> Heartburn			
<input type="radio"/> Heart disease (specify)			
<input type="radio"/> Hepatitis			
<input type="radio"/> High blood fats (cholesterol, Triglycerides)			
<input type="radio"/> Hypoglycaemia (low blood sugar)			
<input type="radio"/> Inflammatory Disease (Chron's or Ulcerative Colitis)			
<input type="radio"/> Intestinal Disease (specify)			
<input type="radio"/> Irritable bowel syndrome			
<input type="radio"/> Kidney disease / failure or Kidney Stones			
<input type="radio"/> Lung disease (specify)			
<input type="radio"/> Liver disease			
<input type="radio"/> Mononucleosis			
<input type="radio"/> Osteoporosis			
<input type="radio"/> PMS			
<input type="radio"/> Polycystic Ovarian Syndrome			
<input type="radio"/> Pneumonia			
<input type="radio"/> Prostate Problems			
<input type="radio"/> Psychiatric Conditions			
<input type="radio"/> Seizures or epilepsy			
<input type="radio"/> Sinusitis			
<input type="radio"/> Sleep Apnea			
<input type="radio"/> Stroke			
<input type="radio"/> Thyroid disease (hypo or hyperthyroid)			
<input type="radio"/> Urinary Tract Infection			
<input type="radio"/> Other (describe)			

Injuries	Age	Describe / Specify
<input type="radio"/> Back injury		
<input type="radio"/> Broken (specify)		
<input type="radio"/> Head injury		
<input type="radio"/> Neck injury		
<input type="radio"/> Other (specify)		

Diagnostic Studies	Age at study	Describe/Specify
Barium Enema		
Bone Scan		
CAT Scan: Abdom., Brain, Spine		
Chest E-ray		
Colonoscopy or Sigmoidoscopy (Specify)		
EKG		
Liver Scan		
NMR/MRI		
Upper GI Series		
Other (describe)		

Operations	Age	Describe / Specify
Dental Surgery		
Gall Bladder		
Hernia		
Hysterectomy		
Tonsillectomy		
Other (describe)		

Please complete the following information concerning your family's health history:

	If Living		If Deceased			If Living		If Deceased	
	Age	Health	Age at death	Cause		Age	Health	Age at death	Cause
Father									
Mother									
Siblings									

MEDICAL SYMPTOMS QUESTIONNAIRE

Rate each of the following symptoms based upon your typical health profile for the past 30 days. If you have been having recent or somewhat severe health symptoms, please indicate that you will fill out the questionnaire for the past 48 hours.

- Past 30 days
- Past 48 hours

Point Scale

0 – Never or almost never have symptoms

1-Occasionally have it, effect is not severe

2-Occasionally have it, effect is severe

3-Frequently have it, effect is not severe

4-Frequently have it, effect is severe

HEAD

_____ Headaches

_____ Faintness

_____ Dizziness

_____ Insomnia

Total _____

EYES

_____ Watery or itchy eyes

_____ Swollen, reddened or sticky eyelids

_____ Bags or dark circles under the eyes

_____ Blurred or tunnel vision

(Does not include near or far-sightedness)

Total _____

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EARS Itchy ears
 Ear aches, ear infections
 Drainage from ear
 Ringing In ears, hearing loss
Total _____

NOSE Stuffy nose
 Sinus problems
 Hay fever
 Sneezing attacks
 Excessive mucus formation
Total _____

MOUTH / THROAT

Chronic cough
 Gagging, frequent need to clear throat
 Sore throat, hoarseness, loss of voice
 Swollen or discoloured tongue, gums
 Canker sores
Total _____

SKIN Acne
 Hives, rashes, dry skin
 Hair loss
 Flushing, hot flashes
 Excessive sweating
Total _____

HEART Irregular skipped heartbeat
 Rapid or pounding heartbeat
 Chest pain
Total _____

LUNGS Chest congestion
 Asthma, bronchitis
 Shortness of breath
 Difficulty breathing
Total _____

DIGESTIVE TRACT

Nausea, vomiting
 Diarrhea
 Constipation
 Bloating feeling
 Belching, passing gas
 Heartburn
 Intestinal / stomach pain
Total _____

JOINT/MUSCLE

Pain or aches in joints
 Arthritis
 Stiffness or limitation of movement
 Pain or aches in muscles
 Feeling of weakness or tiredness
Total _____

WEIGHT

Binge eating / drinking
 Craving certain foods
 Excessive weight
 Compulsive eating
 Water retention

____ Underweight Total _____

ENERGY / ACTIVITY

____ Fatigue, sluggishness
____ Apathy / lethargy
____ Hyperactivity
____ Restlessness Total _____

MIND

____ Poor memory
____ Confusion, poor comprehension
____ Poor concentration
____ Poor physical coordination
____ Difficulty in making decisions
____ Stuttering or stammering
____ Slurred speech
____ Learning disabilities Total _____

EMOTIONS

____ Mood swings
____ Anxiety, fear, nervousness
____ Anger, irritability, aggressiveness
____ Depression Total _____

OTHER

____ Frequent illness
____ Frequent or urgent urination
____ Genital itch or discharge Total _____

GRAND TOTAL _____

MEDICATION, SUPPLEMENT AND ANTIBIOTIC INTAKE: Please provide the names of medications, supplements, and / or antibiotics that you are currently taking:

MEDICATION / SUPPLEMENT / ANTIBIOTIC	DOSE	UNITS	FREQUENCY	START DATE	STOP DATE
Example: One a day (brand) Men's Multivitamin	1200	Mg	Daily	08/12/2007	Current

Are you allergic to any medications? Yes ___ No ___ Please list: _____

Please indicate how often you have taken antibiotics during each life stage:

	>5 Times	<5 Times
Infancy / Childhood		
Teen		
Adulthood		

LIFESTYLE

Physical Activity: Using the table, please describe your physical activity.

Activity	Tyle / Intensity (low-moderate-high)	# Days per week	Duration (minutes)
Stretching / Yoga			
Cardio / Aerobics (walking, jogging, biking, etc)			
Strength-training (weight lifting, pilates, some yoga)			
Sports or Leisure			
Other (Specify/describe)			

Does anything limit you from being physically active?

Indicate daily stressors and rate the level of stress from 1 (extremely low) to 10 (extremely high):

Work ___ Family ___ Social ___ Financial ___ Health ___ Other ___

What helps you unwind:

On average how many hours sleep do you get? Weekdays _____ Weekends _____.

Do you smoke? Never ___ In the past ___ Currently ___ How long? _____

Alcohol use Never ___ In the past ___ Currently Type/amount/frequency _____

Drug use:

Recreational: Never ___ In the past ___ Currently ___ Prefer not to discuss Type/frequency ___

Medicinal: : Never ___ In the past ___ Currently ___ Prefer not to discuss Type/frequency ___

WEIGHT HISTORY

Would you like to be weighed today? Yes ___ No ___

Height _____ Current weight _____ Desired body weight _____

Highest adult weight _____ When _____ Weight one year ago _____

Have you had any changes in your weight that you are concerned about? Yes ___ No ___

DIGESTIVE HISTORY

- Do you associate any digestive symptoms with eating certain foods? Yes ___ No ___

- Please

explain: _____

- How often do you have a bowel movement? _____

- If you take laxatives, what type/brand and how

often: _____

- Would you describe your stools are hard, soft, or loose? (circle one)

- Please indicate how often you experience the following symptoms:

Heartburn	Often	Sometimes	Rarely
Gas	Often	Sometimes	Rarely
Bloating	Often	Sometimes	Rarely
Stomach Pain	Often	Sometimes	Rarely
Nausea/Vomiting	Often	Sometimes	Rarely
Diarrhoea	Often	Sometimes	Rarely
Constipation	Often	Sometimes	Rarely

DIET HISTORY

Do follow any special diet or have diet restrictions or limitations for any reason (health, cultural, religious or other)? Yes ___ No ___ If so please

describe: _____

Please list any food allergies, sensitivities or
intolerances _____

Who prepares your meals? _____ Who shops for food? _____

Where do you shop for food? _____

What percent of the foods you eat are...whole _____ % organic _____ % convenience _____ %

If you do, how much time do you spend cooking / preparing meals each day? _____

Please indicate the materials used for cooking and food storage:

Plastic ___ Glass ___ Aluminium ___ Styrofoam ___ Stainless steel ___ Cast-iron ___ Ceramic ___

Teflon / non-stick ___

Do you find cooking difficult? Yes ___ Please describe:

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INTAKE INFORMATION

If you follow a special diet/nutritional program, check the following that apply:

Low fat _____ Low carb _____ High protein _____ Low sodium _____
 No gluten _____ Vegetarian _____ Vegan _____ Diabetic _____
 No dairy _____ No wheat _____ Weight loss _____ Other _____

Which meals do you eat regularly?

Breakfast? _____ Lunch _____ Dinner/Supper _____ Snacks (time) _____

The nutrition/eating habits that are most challenging for me: _____

The nutrition / eating habits that I am most pleased with: _____

Beverage intake: Please indicate the beverages you drink, and how often you drink them. Fill in the "Daily Amount", "Weekly Amount", and or "Monthly Amount"

Beverage Type	Daily Amount	Weekly Amount	Monthly Amount
Decaf Coffee	2-8 Cups	-	-
Coffee: Regular _____ Decaf _____ Latte _____			
Tea: (What types)			
Juice: Natural _____ Fruit juice			
Soda: Regular _____ Diet _____			
Milk: Whole _____ 2% _____ 1% _____ Skim _____			
Milk alternative type: _____			
Alcohol: wine _____ Beer _____ Liquor _____			
Other: _____			
Water: _____			

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Food intake: Please indicate the frequency that you eat the following:

How often do you eat:	Never	2-3 Times/Mo	1 Time a week	2-3 Times a week	1 Times a day	2-3 Times a day
Fast food						
Restaurant food						
Vending machine food						
Cafeteria or buffet food						
Frozen meals						
Home cooked meals						
Leftovers						
Beef (hamburger, steak, etc)						
Pork (chop, loin, ham, bacon, etc)						
Liver						
Lamb						
Poultry (chicken, turkey, etc)						
Deli meat, type:						
Fish, type:						
Soyfoods, type:						
Beans, type:						
Crackers, type:						
Cookies, cakes, muffins						
Whole grains, type:						
Fresh raw vegetables						
Cooked vegetables						
Canned vegetables or Fruit						
Fruit, fresh or frozen						
Margerine						
Dairy (Milk, Joghurt, cheese, butter)						
French Fries						
Fried meat (chicken/fish)						
Foods with added sweeteners, type:						
Artificial sweetners, type:						
Meal Replacements						

Food cravings: _____

Food dislikes: _____

Eating style: Based on how you eat on a regular basis, please check all that apply:

- Fast eater
- Erratic eater
- Emotional eater (stressed or bored, sad etc)
- Late night eater
- Family members(s) have different tastes
- Love to eat
- Eat too much
- Eat because I have to

__Time constraints

__Dislike "healthy food"

__Travel frequently

__Do not plan meals/menus

__Rely on convenience items

Negative relationship with food__

Struggle with eating issues__

Confused about food/nutrition__

Frequently eat fast food__

Poor snack choices__

The food / nutrition questions that I would like to ask are:
