Nutrition History Form

Height:__________ Weight:__________ Blood Pressure:__________ Age:__________

How would you describe your eating habits? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

What do you want to change about your diet?____
____
____
____

Are you on a diet right now? (If yes, explain)____
____
____
____

Do you diet frequently?____

What foods do you like?____
____
____
____

What foods do you dislike?____
____
____
____

Do you have any food cravings? If yes, what foods?______________________________
____
____
____

How many times per week do you dine out for: Breakfast?__________ Lunch?__________
Dinner?__________

What type of restaurants?____
____
____

What triggers you to eat? (Please check all that apply)

☐ Boredom ☐ Emotions ☐ Hunger ☐ Seeing/Smelling Food ☐ Time of day

☐Physical Activity

Do you have a history of an eating disorder? ☐ Anorexia ☐ Bulimia ☐ Binge Eating

(If yes, please explain) ____
____
____
____

Do you drink ☐ With meals ☐ In between meals ☐ Before meals ☐ After meals

How many eight once glasses of water do you consume daily?___________

Do you regularly eat:

Breakfast? ☐ Yes ☐ No Sample of a typical breakfast:________________________________
____
____
Time:___________

Lunch? ☐ Yes ☐ No Sample of a typical lunch:________________________________
____
____
Time:___________

Dinner? ☐ Yes ☐ No Sample of a typical dinner:________________________________
____
____
Time:___________

Snacks? ☐ Yes ☐ No Sample of a typical snack:________________________________
____
____
Time(s):___________

Are you a:

☐ Vegetarian ☐ Vegan ☐ Lacto-ovo Vegetarian (Dairy and eggs) ☐ Flexitarian

☐ Pescatarian (Fish only) ☐ Lacto-Vegetarian (Dairy only) ☐ Ovo-Vegetarian (Eggs only)

Food Intake Record

Please indicate which foods you eat.

Foods	Less than once a week	Not daily but at least once a week	Daily
Milk, yogurt			
Milk Substitutes: (Circle which) Almond, Coconut, Flaxseed, Rice, Soy, Sunflower			
Cheese			
Red Meat			
Poultry			
Fish			
Eggs			
Mixed Dishes			
Dried Legumes			
Peanut Butter			
Nuts			
Breads, cereal			
Potatoes, pasta, rice			
Crackers, chips, etc.			
Fruits, juices			
Vegetables			
Margarine, butter			
Oils (Circle which) Olive, Canola, Corn, Vegetable, Coconut, Safflower, Sunflower, Soy, Grapeseed, Flaxseed, other:___________			
Salad dressing (What kind?_____________)			
Ice cream			
Cookies, cake, pie			
Candy			
Soft Drink			
Coffee			
Tea, iced tea			
Tofu			
Alcohol (type:____________)			

Supplements/Vitamins

Do you take supplements/Vitamins daily?

 Yes No

If yes, please list:

Vitamin/Supplement	Dose	Brand Name

Physical Activity Questionnaire

Do you exercise? Yes No
If yes, what kind of exercise do you participate in?____
____
____

How often?___________________________________

When exercising, do you feel the following? (Please check all that apply)

 Shortness of Breath
 Chest Pain
 Joint Pain
 Muscle Soreness
 Dizziness