CURRENT NUTRITION INFORMATION

BAY AREA NUTRITION, LLC

FILL IN THIS COLUMN	DIETITIAN'S NOTES
Name_____ Date of Birth_____ Age_____ M F Reason for visit:_____	
Names/Ages of People in your Household_____ _____ _____ Will family participate in any sessions?_____ Describe the support of your family regarding the changes you plan to make:_____	
Height_____ Weight _____ Desired Weight _____ Date of: last physical_____ Lab tests_____ Check any conditions family (extended blood relatives) have or have had: __heart disease __high blood pressure __diabetes/hypoglycemia __high cholesterol __osteoporosis/arthritis __thyroid condition __anemia __cancer __menstrual irregularities __obesity __malnutrition __IBS/Crohn's/GI problems __fibromyalgia __chronic fatigue syndrome __polycystic ovary syndrome Check any conditions you have or have had: __heart disease __high blood pressure __diabetes/hypoglycemia __high cholesterol __osteoporosis/arthritis __thyroid condition __anemia __cancer __menstrual irregularities __obesity __malnutrition __IBS/Crohn's/GI problems __fibromyalgia __chronic fatigue syndrome __polycystic ovary syndrome __anorexia/bulimia/compulsive eating __constipation/diarrhea List any other relevant medical conditions or any condition for which you've been treated in the last year:_____ Have you ever been advised follow any type of diet? If yes, by whom_____, what kind_____, and what changes did you make?_____ _____	
Medications, including any over-the-counter, that you take and why: _____ _____ _____ Vitamin, mineral, food supplements, and herbs that you take, and why: _____ _____	
Do you: use any tobacco products? If yes, list type and frequency:_____ _____ drink alcoholic beverages? If yes, list type, amount and frequency._____ _____ use any non-Rx drugs? If yes, list type, amount and frequency._____ _____ use caffeinated products? If yes, list type and frequency:_____ _____	

Food Intake and Habits

How many days per week do you skip:
breakfast_____ lunch_____ dinner_____

Do you snack? Y N
When?_____
Snack foods?_____

Circle the food group(s) you eat the most of, X through those you lack:

dairy protein fruit vegetables grains fats sweets

Favorite foods?_____
_____

Least favorite foods?_____
_____

How often do you eat out, and what do you usually order:
_____breakfast_____
_____lunch_____
_____dinner_____
_____snacks_____

Beverages: Amount (D)daily or (W)weekly:
__water_____
_____
_____
_____

Who usually:
prepares your food?_____
does your grocery shopping?_____

If you read labels, what do you look for?_____
_____

List others in your household with special diet needs:_____
_____

List the primary factors that influence your food choices (i.e. too busy to cook, allergies):_____

Do you regularly eat: (check those that apply)
__while standing __in the car __too fast
__with others __at the table __watching TV
__while doing other things __everything on your plate

How often do you weigh yourself?_____

How do the numbers on the scale influence your mood and eating habits?
_____
_____

If you want to lose weight, what is your primary motivation?_____
_____

List programs, diets, supplements, etc. that you have used to control your weight:_____
_____

How have they worked?_____
_____

Occupation:_____ Describe your physical activity level on the job:_____	
Do you exercise? If yes, list type, frequency and duration, if no, why not:_____ List other physical activities, such as hobbies and sports:_____	
Describe your usual stress level and primary stressors:_____ How do you manage your stress?_____	
Describe how you've been feeling and if you have any unexplained symptoms:_____	
Food allergies or intolerances: Your reactions to the foods:_____	
What do you think is your most serious nutrition habit/problem?_____ What is motivating you to change your nutrition and food habits?_____ Any other information you think may be important for me to know:_____	
Check the topics of special interest to you: ___**food skills and nutrition knowledge:** non-diet living, label reading/shopping, cooking, kitchen/food prep skills, meal planning, food as medicine, eating out/holidays ___**physical fitness:** energy/activity, strength training, toning, aerobics ___**weight:** loss/maintenance/weight gain, fat loss, gain lean body mass ___**eating problems:** diet obsession, body image issues, disordered eating ___**life stage:** infant/child, pregnancy/lactation, perimenopause, menopause, later years, athletics ___**nutrition management of medical risk/problem:** hypoglycemia, insulin resistant, diabetes, high blood pressure, cardiovascular disease, cancer, allergies, immune dysfunction (CFS, fibromyalgia, arthritis), PCOS, gastrointestinal problems (IBS, Crohn's) ___**supplements:** vitamins/minerals, antioxidants/phytonutrients, herbs ___**optimum health:** well-being, disease prevention	

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Name of Client _____ Date_____

Spouse/Parent's Name(s) _____

Address _____

_____Zip_____

Phone (hm) _____ (wk)_____

Email:_____

Date of Birth _____ Driver Lic # _____ SS# _____

Work Address _____

_____Zip_____

Name of person responsible for bill_____

Address _____

_____Zip_____

Phone (hm) _____ (wk)_____

Date of Birth _____ Driver Lic # _____ SS# _____

Work Address _____

_____Zip_____

Referred by _____

Will you be submitting expenses for nutrition services to your insurance? _____

AUTHORIZATION FOR RELEASE OF INFORMATION

Please provide the following if you have been referred by your physician and/or counselor.
This will allow us to exchange records and work together for you.

I authorize: Bay Area Nutrition and _____(registered dietitian)
621 E. Campbell Ave., Ste-6B, Campbell, CA 95008

to exchange records and discuss my case with:

_____

_____

_____

_____

regarding medical/counseling information related to the nutritional health of the above registered client.

_____ _____
Signature of Client or Responsible Party Date