

CURRENT NUTRITION INFORMATION
BAY AREA NUTRITION, LLC

FILL IN THIS COLUMN	DIETITIAN'S NOTES
Name _____ Date of Birth _____ Age _____ Gender: _____ Preferred Pronoun: _____ 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 ___eating disorder ___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 ___depression/anxiety ___malnutrition ___IBS/Crohn's/GI problems ___fibromyalgia ___chronic fatigue syndrome ___polycystic ovary syndrome ___anorexia/bulimia/binge 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: _____ _____	

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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? _____

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

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CLIENT INFORMATION

Name of Client _____ Date _____

Spouse/Parent's Name(s) _____

Address _____

_____ Zip _____

Phone number(s) _____

Email: _____

Date of Birth _____ Driver Lic # _____

Work Address _____

_____ Zip _____

Name of financially responsible person _____

Address _____

_____ Zip _____

Phone number(s) _____

Email: _____

Date of Birth _____ Driver Lic # _____

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, LLC and _____ (dietitian)

to exchange records and discuss my case with (physicians, therapists, specialists):

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

Signature of Client or Responsible Party

Date