Alamo Nutrition Consultants, LLC
Tel: (210) 971-0044 Fax: (210) 212-7403
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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 Client Nutrition Assessment Form

First Name________________ Middle Name________________ Last Name______________________

Address__________________________________ City_______________ Zip Code________________

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

Home Phone (_____)________-__________ Birth Date _____/_____/_____ Age __________

Work Phone (_____)________-__________ Email address: ____________________________

Cell Phone (_________)________-__________ Height: ___′ ____ ″ Weight: _______ Sex: _____

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 spouse, children, parents, relatives, and/or friends. Please include ages.)

Example: Sarah, age 35, wife

____

____

____

Primary Care Provider (PCP) _________________________ Date of last physical exam ______________

Other doctors or practitioners you see ____

Would you mind if we contact your primary care provider to share medical information? YES NO

If yes, please sign:_____________________________ Office # of PCP__________________________

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GOALS AND READINESS ASSESSMENT

I would like to visit with the dietitian, 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, behaviors, etc. to reach my nutrition goals…

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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					
Modify your lifestyle (ex: work demands, sleep habits, physical activity)					
Engage in regular exercise/physical activity					
Keep a record of everything you eat each day					
Have periodic lab tests to assess your progress (if needed)					

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). Leave Blank if not applicable.

*Relatives include: parents, grandparents, siblings.

Illness/Disease/Symptom	**Self:** Age Diagnosed	**Relative:** Age Diagnosed	**Describe/Specify**
Allergies (please specify type of allergy)			
Anemia			
Anxiety or Panic Attacks			
Arthritis (osteoarthritis or rheumatoid)			
Asthma			
Autoimmune condition (specify type)			
Cancer			
Chronic Fatigue Syndrome			
Crohn's Disease or Ulcerative Colitis			
Depression			
Diabetes (Specify: Type I, II, Prediabetes, Gestational Diabetes)			
Food Allergies or Sensitivities			
Gallbladder Disease/Gallstones (specify)			
Gout			
Heart attack/Angina			
Heart Disease (specify)			
High blood fats (cholesterol, triglycerides)			
High blood pressure (hypertension)			
Irritable bowel syndrome			
Kidney disease/failure or Kidney stones			
Liver disease			
Osteoporosis			
Polycystic Ovarian Syndrome			
Prostate Problems			

Psychiatric Conditions			
Stroke			
Thyroid disease (hypo- or hyperthyroid)			
Other (describe)			
Injuries	**Age**		**Specify**
Head Injury			
Back Injury			
Broken (specify)			
Other (describe)			
Operations:			
Gall Bladder			
Hernia			
Hysterectomy			
Other (describe)			

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.

Point Scale:

0 – Never or almost never have the symptom

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

MOUTH/THROAT

________ Chronic cough
________ Gagging, frequent need to clear throat
________ Sore throat, hoarseness, loss of voice
________ Swollen or discolored tongue, gums, lips
________ Canker sores

SKIN

________ Acne
________ Hives, rashes, dry skin
________ Hair loss
________ Flushing, hot flashes
________ Excessive sweating

HEART

________ Irregular or skipped heartbeat
________ Rapid or pounding heartbeat
________ Chest pain

DIGESTIVE TRACT

________ Nausea, vomiting
________ Diarrhea
________ Constipation
________ Bloated feeling
________ Belching, passing gas
________ Heartburn
________ Intestinal/stomach pain

JOINT/MUSCLE

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

WEIGHT

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

ENERGY/ACTIVITY

________ Fatigue, sluggishness
________ Apathy, lethargy
________ Hyperactivity
________ Restlessness

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MEDICATION, SUPPLEMENT, AND ANTIBIOTIC INTAKE

Please provide the names of medications, supplements, and/or antibiotics that you are currently taking:

Medication/Supplement/ Antibiotic	**Frequency**	**Start Date**
Example: Janumet	1 tablet; 2 times/day	06/2015

Are you allergic to any medications? Yes No

If Yes, please list: ____

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LIFESTYLE

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

Activity	**Type/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 to unwind? ____

On average, how many hours of sleep do you get? Weekdays________ Weekends________

Do you smoke? (circle) Never In the past Currently How long?________
Alcohol use? (circle) Never In the past Currently Times/Week_________
Type/amount____

Drug use? (circle) Never In the past Currently Prefer not to discuss
Type/frequency____

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WEIGHT HISTORY

Height ________ Current Weight _______ Desired Body Weight _______

Highest Adult Weight _______ When? _______ Weight 1 year ago _______

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

If yes, please explain:

____

____

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? Yes No

____

DIET HISTORY

Do you follow any special diet or have diet restrictions or limitations for any reason (health, cultural, religious or other)?

Please list any food allergies, sensitivities or intolerances

____

____

Who prepares the majority of your meals? _____________ _________

Who shops for food? _______________________

Where do you shop for food?

____

What percent of the foods you eat are…

whole ________% organic________% convenience(take-out) _________%

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

____

Do you enjoy cooking? Yes No

Do you find cooking difficult? Yes No Explain_____________________________

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INTAKE INFORMATION:

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

Low Fat	Low Carb	High Protein	Low Sodium
Gluten Free	Vegetarian	Vegan	Diabetic
No Dairy	No Wheat	Low Calorie	Other

Which meals do you eat regularly, circle all that apply:

Breakfast Lunch Dinner Snacks (times)______________________

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

____

____

____

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

____

____

____

Beverage Intake: Please indicate the beverages you drink, how much and how often you drink them.

Beverage	**Amount (**in ounces or cups)	**Times per Day**
Coffee □ decaf □regular □latte		
Tea What kind______________		
Water		
Sodas □diet □regular		
Juice		
Milk		
Milk Alternative What kind_____________		
Alcohol □wine □beer □liquor		
Other		

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Eating Out:

How often do you eat out? Circle your response

once/day	twice/day	three/day	1-2/week
2-4/week	3-5/week	5-7/week	Other____________

Which restaurants or fast food places do you normally eat at?

____
____
____

Which foods do you normally crave?

____
____
____

Which foods do you dislike?

____
____
____

Eating Style: Based on how you eat on a regular basis, please circle all that apply:

Fast Eater	Late Night Eater	Erratic Eater
Time constraints	Dislike “Healthy” food	Travel Frequently
Don’t plan meals	Rely on convenience items	Love to Eat
Eat too much	Eat because I have to	Struggle with eating issues
Confused about nutrition	Eat a lot of fast food	Other________________