Nutrition and Health History Form

Please complete this questionnaire. All information will be kept strictly confidential.

PERSONAL INFORMATION:

Name: ____________________________________ Date: ______________________

Address:___________________________________ Postal Code:_________________

Telephone: (H) _____________________________ (B) ________________________

Occupation: _______________________________ Employer:____________________

Date of Birth: _____________________________ Age: _______________________

Marital Status: ___________________________ Any Children:_____________________

What is your reason for wanting to see a Dietitian: ______________________________

____

On a scale of 1 to 10 (1 being low and 10 high) rate your nutrition knowledge: _________

MEDICAL BACKGROUND:

Are there any medical conditions that the Dietitian should be aware of: ____________

____

Family Medical History:____

Are you taking any medication presently? Yes No

If yes, what?____

Do you have any food sensitivities or food allergies? Yes No

If yes, what?____

Are you taking any vitamin / mineral / herbal supplements? Yes No

If yes, what?____

Do you use any other health services? Yes No

If yes, what? ____

LIFESTYLE HABITS:

What time do you wake?: ________ On avg how many hours sleep per night? ______

Do you skip meals? Yes No If so which one(s): ________________________________

Do you drink coffee? Yes No If yes, how many cups / day? ________________

Do you drink tea? Yes No If yes, how many cups / day? ________________

Do you drink milk? Yes No If yes, how many cups / day? ________________

Do you drink water? Yes No If yes, how many cups / day? ________________

Do you drink pop? Yes No If yes, how many cups / day?_________________

Is the pop you drink diet? Yes No ____

Do you like Milk and Milk products: Yes No _____________________________________

Do you like Fruits and Vegetabls: Yes No _____________________________________

Do you like Meat and Alternatives (ie fish,beef chicken, lentils, legumes,eggs)? Yes No

____

Which foods do you avoid for religious / ethical / cultural reasons? ________________

____

Alcohol per week: ________Do you smoke? Yes No If yes, how much? _________

What physical activity do you do? ____

How often do you exercise?____

Par-Q & You: (Physical Activity Readiness Questionnaire)

Yes No 1. Has your doctor ever said you have heart trouble and that you should only do physical activity recommended by a doctor?

Yes No 2. Do you feel pain in your chest when you do physical exercise?

Yes No 3. In the past month, have you had chest pain when you were not doing physical activity?

Yes No 4. Do you lose your balance because of dizziness or do you ever lose consciousness?

Yes No 5. Do you have a bone or joint problem that could be made worse by a change in your physical activity?

Yes No 6. Is your doctor currently prescribing drugs (i.e., water pills) for your blood pressure or heart condition?

Yes No 7. Do you know of any other reason why you should not do physical activity?

Source: The Canadian Society for Exercise Physiology, Health Canada. 1994

Office Policy: (ALL CLIENTS please read)

Please help us to maintain the operation of our office on sound principles so that we may assure you and other clients of uninterrupted service. Once you have made an appointment, this time is reserved for you, therefore **at least 24 hours NOTICE must be given if cancellation is absolutely necessary – otherwise a $40.00 fee will be charged.** Services are paid for at each visit. However, in certain circumstances arrangements for payment may be made with the dietitian or clinic.

Regarding insurance: All professional services are CHARGED DIRECTLY TO THE CLIENT. We will prepare any necessary forms or reports to help you collect your benefits from insurance companies.

Client’s Signature: ______________________________ Date: ______________________________

Name: ______________________________

Please list all foods/fluids that go into your mouth ie.
1 cup coffee, 1 tsp sugar, 1 tsp 1% milk, 2 slices whole wheat bread, 1 tsp peanut butter, 1 cup water

	Day 1	Day 2	Day 3
Breakfast Time: Where:			
Snack Time: Where:			
Lunch Time: Where:			
Snack Time: Where:			
Dinner Time: Where:			
Snack Time: Where:			