SANDY ZOHNI *MS RD CDN CDE*

NEW PATIENT NUTRITION HEALTH ASSESSMENT FORM

MEDICAL HISTORY: (CHECK ALL THAT APPLY)

- ☐ ACID REFLUX (GERD)
- ☐ CELIAC
- ☐ CROHNS
- ☐ COLITIS
- ☐ DIVERTICULITIS
- ☐ IBS
- ☐ CONSTIPATION
- ☐ KIDNEY DISEASE
- ☐ DIABETES
- ☐ THYROID DISEASE
- ☐ HEART DISEASE
- ☐ HYPERTENSION
- ☐ ASTHMA
- ☐ SLEEP APNEA
- ☐ ALLERGIES
- ☐ COPD
- ☐ ARTHRITIS
- ☐ GOUT
- ☐ ANXIETY
- ☐ DEPRESSION
- ☐ CANCER

WOMEN:

☐ PCOS ☐ GESTATIONAL DIABETES ☐ PREECLAMPSIA DURING PREGNANCY

IF YOU CHECKED ANY OF THE ABOVE CONDITIONS, PLEASE DESCRIBE BRIEFLY

____

____

ANY SURGERIES?

____

____

LIST ALL MEDICATIONS: ____

____

LIST ANY ALLERGIES.

____

FAMILY HISTORY

☐ HEART DISEASE ☐ HYPERTENSION ☐ DIABETES ☐ CANCER

HAVE ANY OF YOUR CLOSE RELATIVES HAD A SUDDEN HEART ATTACK OR STROKE BEFORE 60?

YES ☐ NO ☐. IF YES, PLEASE GIVE DETAILS

____

____

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LIFESTYLE

PHYSICAL ACTIVITY: USING THE TABLE, PLEASE DESCRIBE YOUR PHYSICAL ACTIVITY:

ACTIVITY TYPE	**DAYS PER WEEK**	**DURATION**	**INTENSITY (LOW-MODERATE-HIGH)**
STRETCHING/YOGA			
CARDIO / AEROBICS (WALKING, BIKING, JOGGING, ETC.)			
STRENGTH TRAINING (WEIGHTLIFTING, PILATES, SOME YOGA)			
SPORTS OR LEISURE			
OTHER (SPECIFY/DESCRIBE)			

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ARE YOU CONSISTENT WITH YOUR EXERCISE ROUTINE? HOW LONG HAVE YOU BEEN FOLLOWING IT?

____

____

DO YOU ENJOY EXERCISE?

____

____

DOES ANYTHING LIMIT YOU FROM BEING PHYSICALLY ACTIVE? IF SO, WHEN WAS THE LAST TIME YOU WERE ENGAGED IN AN EXERCISE ROUTINE?

____

____

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 RELAX?

____

____

WHAT TIME DO YOU USUALLY GO TO BED? ____

ON AVERAGE, HOW MANY HOURS OF SLEEP DO YOU GET?

WEEKDAYS_________________ WEEKENDS_____________________

DO YOU FEEL SLUGGISH WHEN YOU DON'T SLEEP ENOUGH?

____

____

DO YOU SMOKE? □DAILY □OFTEN □OCCASIONALLY □NEVER

SANDY ZOHNI *MS RD CDN CDE*

DO YOU DRINK ALCOHOL? □DAILY □OFTEN □OCCASIONALLY □NEVER

WEIGHT HISTORY:

HEIGHT ____________________CURRENT WEIGHT __________________ DESIRED BODY WEIGHT _________________

HIGHEST ADULT WEIGHT ________________ WHEN? _________

LOWEST ADULT WEIGHT _________________WHEN? _________

WHICH PLANS, TECHNIQUES, DIETS, BEHAVIORAL CHANGES, ETC. HAVE YOU EVER TRIED TO LOSE WEIGHT?

____

____

WHICH PLANS HAVE WORK BEST? AND FOR HOW LONG WERE YOU ABLE TO KEEP THE WEIGHT OFF?

____

____

HAVE YOU HAD ANY RECENT UNPLANNED CHANGES IN YOUR WEIGHT? □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?

____

____

ANY RECENT CHANGES IN YOUR BOWEL MOVEMENT?

____

____

IF YES, PLEASE EXPLAIN:

____

____

IF YOU TAKE LAXATIVES, WHAT TYPE/BRAND AND HOW OFTEN?

____

____

PLEASE CHECK ANY OF THE SYMPTOMS YOU EXPERIENCE ON A REGULAR BASIS. CHECK ALL THAT APPLY.

□HEARTBURN □GAS □BLOATING □STOMACH PAIN

□NAUSEA □VOMITING □DIARRHEA □CONSTIPATION

DIET HISTORY

DO YOU HAVE ANY DIET RESTRICTIONS OR LIMITATIONS FOR ANY REASON (HEALTH, CULTURAL, RELIGIOUS OR OTHER)?

□YES □NO IF YES, PLEASE DESCRIBE

____

____

PLEASE LIST ANY FOOD ALLERGIES, SENSITIVITIES, OR INTOLERANCES

____

____

WHO PREPARES THE MAJORITY OF YOUR MEALS?

____

____

WHO SHOPS FOR FOOD?

____

____

DO YOU FIND COOKING DIFFICULT? □YES □NO

IF YES, PLEASE DESCRIBE

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____

____

HOW OFTEN DO YOU EAT OUT?

____

____

DO YOU MAKE MINDFUL SELECTIONS WHEN EATING OUT? □YES □NO

IF YES, PLEASE DESCRIBE

____

____

INTAKE INFORMATION:

PLEASE CHECK ANY OF THE FOLLOWING THAT DESCRIBE YOUR CURRENT INTAKE:

□ LOW FAT □ LOW CARB □ HIGH PROTEIN □ LOW SODIUM

□ GLUTEN-FREE □ VEGAN □ PLANT BASE □ DIABETIC

□ DAIRY-FREE □ WEIGHT LOSS □ OTHER____

HOW MANY MEALS DO YOU EAT ON A TYPICAL DAY?

____

____

CHECK ALL THAT APPLY:

□ BREAKFAST □ LUNCH □ DINNER SNACKS: □ AM □ PM □ LATE NIGHT

WHICH ONE IS YOUR HEAVIEST MEAL? ____

WHAT TIME IS YOUR LAST MEAL? ____

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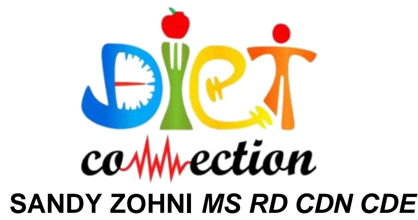

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WHAT IS THE MOST CHALLENGING ASPECT OF TRYING TO EAT HEALTHIER?

____

____

WHAT HAVE YOU BEEN ABLE TO CHANGE SO FAR?

____

____

FOOD CRAVINGS

____

____

FOOD DISLIKES

____

____

HOW WOULD YOU DESCRIBE YOUR EATING HABITS? PLEASE CHECK ALL THAT APPLY:

☐ I'M NOT STRUCTURED WITH MY MEALS	☐ I'M A FAST EATER	☐ I LIVE TO EAT	☐ I EAT TO LIVE
☐ I'M A LATE NIGHT-EATER	☐ PORTION IS A BIG ISSUE	☐ I SNACK TOO MUCH	☐ I'M AN EMOTIONAL EATER
☐ I DON'T PREPARE MY MEALS AHEAD	☐ I EAT OUT A LOT	☐ I ENJOY HEAVY FOOD	☐ I SKIP MEALS
☐ I DON'T ENJOY HEALTHY FOOD	☐ LOVE "JUNK FOOD"	☐ I DON'T LIKE VEGGIES	☐ I'M A VERY PICKY EATER
☐ I HAVE NO TIME TO EAT	☐ I AM AFRAID TO EAT	☐ I OVEREAT	☐I UNDER EAT
☐ I LOVE TO EAT			

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