Name		Da	te					
Marital Status		Ag	e					
Reason for today's visit								
,								
Number of people living	in vour househo	ald Nu	ımber of child	ron				
	-	na Ne	iniber of crina	ien				
Check off any Health Iss	ues that apply:							
Diabetes		Irritable Bowel Syndrome		Polycystic Ova				
Renal Disease		Diverticulosis		Food Allergies		<u> </u>		
Heart Disease		GERD/Reflux		Stress		Ļ		
High Cholesterol/TG		Chronic Headaches/Migraines		Constipation		<u>L</u>		
High Blood Pressure		Thyroid Disease		Crohn's Disease				
Cancer		Overweight/Obesity		Colitis				
Sleep Apnea		Eating Disorder		Celiac Disease				
Family History of above Current Medications Vitamin/Mineral/Herbal								
Recent Lab Data (If Ava	ilable)							
Cholesterol	LDL	HDL		TG				
Fasting Blood Sugar		HemoglobinA1c		Blood Pressure				
Nutrition and Exercise I	Habits							
Height	Weight	Desired Weight		ВМІ	(leave blank)			
Highest Adult Weight		Lowest Adult Weig	ht					
Have you lost or gained weight recently? Yes No								

If yes, please explain	
Do you smoke? Yes No	
If yes, How much	
How much alcohol do you drink per/day	per/week
Do you have any religious/cultural factors affecting your diet?	
What is your previous diet experience?	
Who is responsible for the food purchase?	
The preparation?	
How many times do you eat out per week?	
How many home cooked meals do you eat at home per week	Take out
Do you exercise? Yes No	
If yes, how often and for how long?	
What types of exercise do you do?	
On a scale of 1 to 10, how motivated are you to change your die	t or to lose weight?
	a con con concentration
Using the same scale, how confident are you?	

Food Recall: What have you eaten in the last 24 hours? Or on a typical days intake

Breakfast	Snack	Lunch	Snack	Dinner	Snack