Peterson Nutrition & Fitness
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Patient Intake Form

Personal Data

Name: _____ Date: _____

Housing: _____. Date of last: Medical Exam: _____ Medication Change: _____ Dental Exam: _____
(I live with)

Allergies: _____

List current medications: _____
List food and/or vitamin/mineral supplements: _____

Weight History - Answer all that apply

Present Wt: _____ Wt at birth: _____ Wt in preschool: _____ Wt at age 12: _____ , age 20 _____

age 30 _____ , age 40 _____ , age 50 _____, age 60 _____, on Wedding day _____ (yr. _____). Desired Wt: _____

Maximum: _____/_____/_____ Lowest: _____/_____/_____ Desired: -
_____/_____/_____
wt. date lasted wt. date lasted wt. date lasted

I weigh myself: _____ times a: (circle one) day week month. Where do you weigh yourself? _____

History - Indicate as follows: "I"- Self , "M"- Mother, "F"- Father, "S"- Sibling and "G"- Grandparents

Family Medical

Arthritis		Dizziness		Heart trouble		Kidney trouble	
Asthma		Epilepsy		Headaches		Obesity	
Diabetes		Fatigue		Hypertension		Ulcers	

Family Social/Behavioral

Alcoholism		Depression		Nightmares		Rape	
Anorexia Nervosa		Drug Addiction		Phobias		Self Mutilation	
Bulimia Nervosa		Emotional Abuse		Physical Abuse		Sexual Abuse	
Binge Eating		Incest		Psychotherapy		Stealing	
Compulsive Behaviors		Mood Swings		Psychiatric Hospitalization		Secretive Behaviors	

Sexual Orientation

Heterosexual _____ Homosexual _____ Bisexual _____ Sexually Inactive _____ Unaware of _____

Physical Symptoms - Indicate as follows: "Y" – Yes or leave blank if No. If yes, please give details.

Do you experience gastrointestinal problems? _____. Diarrhea____, Constipation ____, Abdominal Pain/Bloating ____, Nausea _____, Reflux_____. Details: _____.

Have you ever vomited blood? _____. Details: _____.

Have you observed changes in your hair _____, nails _____, teeth _____,skin _____,vision _____ as a result of your eating behaviors?
Details: _____.

Does your eating or restricting effect your energy level _____, concentration _____, vision _____, or ability to sleep _____?
Details: _____.

Have you ever been hospitalized for an eating disorder? _____. How often? _____. Dates: _____
For how long? _____ Where? _____

How do you view that experience? _____

Have you ever been hospitalized for another reason? Details: _____
_____

Females only: Age _____, Weight _____ at time of first menses. Are you on prescribed birth control? _____ Type _____
Date of your last menstrual cycle _____. Number of days between periods _____. Number of days period lasts _____.

Diet History

Age you first started dieting? _____ Weight at beginning _____. Weight at end _____.
Why did you begin to diet? _____
Who influenced your desire to lose weight? _____

Exercise History - Fill in either Y – Yes or N – No. If yes, give details.

Are you currently exercising? _____
Details: Type of exercise Minutes per day Days per week
_____
_____
_____

Do you or have you ever participated in intramurals, Olympic competition, professional sport or dance? _____
Details: Type of participation Minutes per day Days per week
_____
_____
_____

Eating Behaviors: In each blank, place one letter that best corresponds with your eating behavior.

A – Always U - Usually S - Sometimes R - Rarely N - Never

1. I eat 1, 2, 3 (circle one) meals each day. _____
2. I eat when I am hungry. _____
3. I eat 3 meals with 1, 2, 3 (circle one) snacks. _____
4. I rigidly restrict my food intake. _____
5. I restrict in the day and overeat in the evening. _____
6. I restrict the intake of specific foods. _____
   List:
7. I restricted my intake at specific times. _____
   List:
8. I binge without purging. _____
9. I graze all day long. _____
10. I go to sleep feeling stuffed ____, empty ____, satisfied _____.
11. Once I start eating, I don't stop. _____
12. I binge and then I exercise excessively ____, vomit _____ laxatives ___, restrict ___, take diuretics ___, diet pills____.
13. When I don't binge, I exercise excessively ____, vomit _____ laxatives ___, restrict ___, take diuretics ___, diet pills____.
14. I eat whatever I want ____. Without regret ____.
15. I eat whatever I want ____. With regret _____.
16. I eat whatever I want, and then exercise excessively ____, vomit _____, use laxatives ____, take diuretics ____.

Behavior Frequency – Number of times

	Currently			In the Past			
	Per day	Per week	Per Month	Maximum	Date	Minimum	Date
Exercise							
Vomit							
Restrict							
Overeat/binge							
Take diuretics							
Take diet pills							
Take laxatives							
Drink coffee/tea (cups)							
Drink caffeinated beverages							
Drink Water							
Smoke Cigarettes							
Alcohol Intake							

Have your worked with a dietitian or nutritionist? Yes ____ No____. If yes, who _____ when _____.
What are your goals in working with a dietitian now? _____
_____
_____