# CURRENT NUTRITION INFORMATION

**BAY AREA NUTRITION, LLC**

| FILL IN THIS COLUMN | DIETITIAN'S NOTES |
|---|---|
| Name_____<br>Date of Birth_____Age_____<br>Gender: _____ Pronoun: _____<br>Reason for visit:_____ | |
| Names/Ages of People in your Household_____<br>_____<br>_____Will family participate in any sessions?_____<br>Describe the support of your family regarding the changes you plan to make:_____ | |
| Note: only provide this info if you are comfortable: Height_____<br>Weight _____Desired Weight _____<br>Date of: last physical_____ Lab tests_____<br>Check any conditions family (extended blood relatives) have or have had:<br>__heart disease __high blood pressure __diabetes/hypoglycemia<br>__high cholesterol __osteoporosis/arthritis __thyroid condition<br>__anemia __cancer __menstrual irregularities<br>__eating disorder __malnutrition __IBS/Crohn's/GI problems<br>__fibromyalgia __chronic fatigue syndrome __polycystic ovary syndrome<br>Check any conditions you have or have had:<br>__heart disease __high blood pressure __diabetes/hypoglycemia<br>__high cholesterol __osteoporosis/arthritis __thyroid condition<br>__anemia __cancer __menstrual irregularities<br>__depression/anxiety __malnutrition __IBS/Crohn's/GI problems<br>__fibromyalgia __chronic fatigue syndrome __polycystic ovary syndrome<br>__anorexia/bulimia/binge eating __constipation/diarrhea<br>List any other relevant medical conditions or any condition for which you've been treated in the last year:_____<br>Have you ever been advised follow any type of diet? If yes, by whom_____, what kind_____, and what changes did you make?_____<br>_____ | |
| Medications, including any over-the-counter, that you take and why:<br>_____<br>_____<br>_____<br>Vitamin, mineral, food supplements, and herbs that you take, and why:<br>_____<br>_____ | |
| Do you: use any tobacco products? If yes, list type and frequency:__<br>_____<br>drink alcoholic beverages? If yes, list type, amount and frequency.__<br>_____<br>use any non-Rx drugs? If yes, list type, amount and frequency._____<br>_____ | |

use caffeinated products? If yes, list type and frequency:_____
_____

**Food Intake and Habits**

How many days per week do you skip:
breakfast_____ lunch_____ dinner_____

Do you snack? Y N
When?_____
Snack foods?_____

Circle the food group(s) you eat the most of, X through those you lack:
dairy protein fruit vegetables grains fats sweets

Favorite foods?_____
_____

Least favorite foods?_____
_____

How often do you eat out, and what do you usually order:
_____breakfast_____
_____lunch_____
_____dinner_____
_____snacks_____

Beverages: Amount (D)daily or (W)weekly:
___water_____
_____
_____

Who usually:
prepares your food?_____
does your grocery shopping?_____

If you read labels, what do you look for?_____
_____

List others in your household with special diet needs:_____
_____

List the primary factors that influence your food choices (i.e. too busy to cook, allergies):_____

Do you regularly eat: (check those that apply)
__while standing __in the car __too fast
__with others __at the table __watching TV
__while doing other things __everything on your plate

How often do you weigh yourself?_____

How do the numbers on the scale influence your mood and eating habits?
_____
_____

If you want to lose weight, what is your primary motivation?_____
_____

List programs, diets, supplements, etc. that you have used to control your weight:_____
_____

How have they worked?_____

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|---|---|
| Occupation:_____<br>Describe your physical activity level on the job:_____<br>_____ | |
| Do you exercise? If yes, list type, frequency and duration, if no, why not:<br>_____<br>_____<br>List other physical activities, such as hobbies and sports:_____<br>_____ | |
| Describe your usual stress level and primary stressors:_____<br>_____<br>_____<br>How do you manage your stress?_____<br>_____<br>_____ | |
| Describe how you've been feeling and if you have any unexplained symptoms:_____<br>_____<br>_____ | |
| Food allergies or intolerances: Your reactions to the foods:<br>_____<br>_____<br>_____<br>_____ | |
| What do you think is your most serious nutrition habit/problem?___<br>_____<br>What is motivating you to change your nutrition and food habits?__<br>_____<br>_____<br>_____<br>Any other information you think may be important for me to know:_<br>_____<br>_____ | |
| **Check the topics of special interest to you:**<br>___**food skills and nutrition knowledge:** non-diet living, label reading/shopping, cooking, kitchen/food prep skills, meal planning, food as medicine, eating out/holidays<br>___**physical fitness:** energy/activity, strength training, toning, aerobics<br>___**weight:** loss/maintenance/weight gain, fat loss, gain lean body mass<br>___**eating problems:** diet obsession, body image issues, disordered eating<br>___**life stage:** infant/child, pregnancy/lactation, perimenopause, menopause, later years, athletics<br>___**nutrition management of medical risk/problem:** hypoglycemia, insulin resistant, diabetes, high blood pressure, cardiovascular disease, cancer, allergies, immune dysfunction (CFS, fibromyalgia, arthritis), PCOS, gastrointestinal problems (IBS, Crohn's)<br>___**supplements:** vitamins/minerals, antioxidants/phytonutrients, herbs<br>___**optimum health:** well-being, disease prevention | |

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## CLIENT INFORMATION

**Name of Client** _____ Date_____

Spouse/Parent's Name(s) _____

Address _____

_____Zip_____

Phone number(s) _____ _____

Email(s): _____

Date of Birth _____ Driver Lic # _____

Work Address _____

_____Zip_____

**Name of financially responsible person**_____

Address _____

_____Zip_____

Phone number(s) _____ _____

Email: _____

Date of Birth _____ Driver Lic # _____

Work Address _____

_____Zip_____

Referred by _____

Will you be submitting expenses for nutrition services to your insurance?_____

## AUTHORIZATION FOR RELEASE OF INFORMATION

Please provide the names and contact info of your providers. This will allow us to exchange records and work together for you.

I authorize: Bay Area Nutrition, LLC and _____ **(dietitian)**

to exchange records and discuss my case with the following people:

_____

_____

_____

_____

regarding medical/counseling information related to the nutritional health of the above registered client.

_____ _____

Signature of Client or Responsible Party Date