***Christina Scribner MS RD CSSD***

• Registered Dietitian • Board Certified Specialist in Sports Dietetics•

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**PATIENT MEDICAL HISTORY FORM**

The following information is very important to your health. Please take the time to fully and completely fill out each page.

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB:\_\_\_\_\_\_\_\_\_\_\_AGE: \_\_\_\_Gender: \_\_\_\_\_\_

Please check one:

**Initial\_\_\_\_\_\_**□ I **DO** give Christina Scribner permission to contact me by **e-mail** by. EMAIL:\_\_\_ **Initial\_\_\_\_\_\_**□ I **DO NOT** give Christina Scribner permission to contacted me by **e-mail**.

**Initial\_\_\_\_\_\_**□ I **DO** give Christina Scribner permission to leave a confidential message at the following **phone** numbers: Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Initial\_\_\_\_\_\_**□ I **DO NOT** give Christina Scribner permission to leave a confidential **phone** message.

**Initial\_\_\_\_\_\_**□ I **DO** give Christina Scribner permission to leave a phone **text** message at the following **phone** numbers: Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Initial\_\_\_\_\_\_**□ I **DO NOT** give Christina Scribner permission to leave a phone **text** message.

Reason for visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any recent diagnostic tests for this problem? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who is your Primary Care Physician? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

### Referred by:

□ Self □ Health care provider….. Name? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Coach □ Other………\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Why do you want to see the nutritionist?**  (Check all that apply)

|  |  |  |
| --- | --- | --- |
| 1. □ General healthy eating advice
 | 1. □ Sport nutrition advice
 | 1. □ High cholesterol
 |
| 1. □ Want to lose weight
 | 1. □ Vegetarian eating
 | 1. □ High blood pressure
 |
| 1. □ Want to gain muscle/weight
 | 1. □ Disordered eating/eating concerns
 | 1. □ Diabetes
 |
| 1. □ Gastrointestinal problems
 | 1. □ Food sensitivity/allergy/ intolerance
 | 1. □ Fatigue
 |
| 1. □ Other (please explain): \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |

How long have you had this condition/disease?

Symptoms associated with this condition/disease:

How has your life been effected by your medical condition?

What strengths/skills/personality characteristics do you bring to this problem that will help you overcome it?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current and Past Medical Treatment: Date or age at time of treatment

|  |  |
| --- | --- |
| Treatment for: | Date: |
|  |  |
|  |  |
|  |  |

**CURRENT MEDICATIONS:**

Medication Dose Frequency Medication Dose Frequency List all medications you are taking:

|  |  |  |  |
| --- | --- | --- | --- |
| Medication | Time of Day | Amount | Reason for Taking |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**SOCIAL HISTORY:**

**Ethnicity/Race: If bi-racial, or multi-racial please check all that apply:**

□ African-American □ Arab American □ Asian

 □ Pacific Islander □ Caucasian, European-American

□ Chicano, Latino, Hispanic □ Native American□ Alaskan Native

 □ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

### Religious Affiliation/Spirituality:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

### Is spirituality *or* religion an important part of health care for you? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

### Do you identify as having a disability? □ No □ Yes If Yes, please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you a parent? □ No □ Yes If, Yes, please list the age & gender of your children: \_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_

### STUDENTS ONLY Major: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**College Class**: □Freshman □Sophomore □Junior □Senior □5th Year □Graduate □Transfer Student □Continuing Education Other: \_\_\_\_\_\_\_\_\_\_

**School Status:** □Full-time □Part-time

**Housing:** □Residence: □Residence Hall □Off-Campus □Greek

**Secondary School**: □Freshman □Sophomore □Junior □Senior
Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Name of School:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EMPLOYMENT**

Employment**:** □Full-time □Part-time Type of Work: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Volunteer work: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**LIVING CONDITIONS:**Current Relationship Status:
□ Single □ Married or Partnered □ Separated □ Divorced □ Widowed □ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Who do you live with? □ Roommate □ Spouse □ Children □ Parents □ Other \_\_\_\_\_\_\_\_
Are you satisfied with the living arrangement? □ Yes □ No
Explanation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who shops for food? □ Self □ Roommate □ Spouse □ Parents □ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 Who cooks? □ Self □ Roommate □ Spouse □ Parents □ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 What types of transportation do you use? □ Walk □ Bicycle □ Skateboard □ Auto □ Bus □ Other \_\_\_\_\_

**PATIENT AND FAMILY MEDICAL HISTORY**

**PERSONAL Medical History: Place a check mark in front of the conditions you have or have had**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| [ ]  | Allergies (food) | [ ]  | Anemia | [ ]  | Arthritis |
| [ ]  | Back Pain | [ ]  | Cancer (type \_\_\_\_\_\_\_\_) | [ ]  | Constipation |
| [ ]  | Diabetes  | [ ]  | Diarrhea | [ ]  | Dental/Chewing  |
| [ ]  | Dizziness | [ ]  | Eating Disorder | [ ]  | Fainting |
| [ ]  | Food Sensitivities | [ ]  | Fibromalagia | [ ]  | Gastrointestinal |
| [ ]  | Gallbladder Disorder | [ ]  | Gout | [ ]  | Hair Loss |
| [ ]  | High Blood Pressure | [ ]  | High Blood Cholesterol | [ ]  | High Blood Triglycerides |
| [ ]  | Heart Disease | [ ]  | Hypoglycemia | [ ]  | Irregular Heart Beat  |
| [ ]  | Kidney Disease | [ ]  | Liver Disease | [ ]  | Migraines |
| [ ]  | Muscle/Joint | [ ]  | Osteoporosis/osteopenia | [ ]  | Other Allergies |
| [ ]  | Overweight/Obesity | [ ]  | Polycystic Ovaries | [ ]  | Reflux/Heartburn |
| [ ]  | Sleep Apnea | [ ]  | Thyroid Problems | [ ]  | Urinary tract infections |
| [ ]  | Ulcer | [ ]  | Victim of Abuse | [ ]  | Sexually Transmitted  |
| [ ]  | Depression | [ ]  | Anxiety Disorder | [ ]  | Substance Abuse |
|  | Other \_\_\_\_\_\_\_\_\_\_\_\_ |  | Other\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Abnormal Labs or Family History  | Date of Labs:   |
| List Any Foods You are Allergic to:  |
| List Any Foods You do not Tolerate (but are not allergic to):  |

Do you commonly experience any of the following symptoms?  (Check all that apply)

[ ]  Fatigue/Low energy

[ ]  Cold sensitivity

[ ]  Loss of appetite

[ ]  Light-headedness/dizziness

[ ]  Extreme hunger

[ ]  Irritability or moodiness

[ ]  Frequent illness or injury

[ ]  Poor concentration

[ ]  Thinking about food, eating, or not eating often

 **FOR FEMALES ONLY:**

1) Do you have regular menstrual periods?       [ ] Y           [ ] N

2) Have you ever lost your period for three months or longer?   [ ] Y           [ ] N

3) Do you take oral contraceptives?            [ ] Y           [ ] N

**SLEEP PHYSICAL ACTIVITY**

What time do you generally go to bed? \_\_\_\_\_\_\_\_am/pm

What time do you generally wake‐up? \_\_\_\_\_\_\_\_ am/pm

On average, how many hours do you sleep per night/day?
 [ ] 3-5       [ ] 6-7       [ ]  7-9      [ ]  10 or more Is this enough?    [ ] Y           [ ] N

Please identify your typical level of physical activity:

 [ ] Level 1: Activities of Daily Living Only

 [ ] Level 2: Activities Equivalent to Walking 2-3 miles/d plus other Activities of Daily Living

 [ ] Level 3:  Activities Equivalent to Walking ~5-8miles/d plus other Activities of Daily Living

 [ ] Level 4:  Activities Equivalent to Walking ~10-20 miles/d plus other Activities of Daily Living

Regular weekday physical activities include:

|  |  |  |  |
| --- | --- | --- | --- |
| Type of activity:  | Frequency (days/week):  | Duration (length of workout):  | Intensity (light. moderate, high):  |
|   |   |   |   |
|   |   |   |   |
|   |   |   |   |
|   |   |   |   |

Regular physical activities on weekends includes:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please identify anything that limits or prevents you from being physically active:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever felt that your exercise was compulsive and or excessive? [ ] **Y**[ ] **N**

Are you are a student‐athlete? [ ] **Y**[ ] **N**

 [ ] Intercollegiate or Intramural Team; (Please specify which team: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

 [ ] School Team; (Please specify which team: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

**Quality of Life:**

**Please evaluate the following**

How would you describe your personality Type?
□ Impatient □ Time-oriented □ Competitive

□ Usually somewhat relaxed □ Sometimes anxious □ Relaxed and easy going

Stress Level……………………….. □ Low □ Moderate □ Severe

Major Sources of Stress \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Do practice stress-reduction techniques? □ No □ Yes If yes, please describe: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
Quality of Social Life ……………. □ V. Poor □ Poor □ Adequate □ Good □ Excellent

Quality of Mental Health………… □ V. Poor □ Poor □ Adequate □ Good □ Excellent

Quality of Physical Health……… □ V. Poor □ Poor □ Adequate □ Good □ Excellent
Do you have a support system? □ No □ Yes Who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**BODY WEIGHT**

What is your current body weight? **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

What is your current body height? **\_\_\_\_\_\_\_\_\_\_\_\_**

How long have you been at your current weight? \_\_\_\_\_**\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_

Lowest adult weight:  \_\_\_\_\_ lbs   When?  \_\_\_\_\_/\_\_\_\_\_   (month/year)

Highest adult weight:\_\_**\_\_\_\_\_\_\_\_** lbs   When?  \_\_\_\_\_/\_\_\_\_\_   (month/year)

What do you consider to be your “best” weight? \_\_\_\_\_\_\_\_\_\_\_ Why? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**BODY IMAGE**

Are you satisfied with your body weight and shape? [ ] **Y**[ ] **N**
If not, what change(s) would you like?

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Frequency of Weighing Self:

[ ]  multiple times per day [ ]  once daily [ ]  once weekly [ ]  infrequently [ ]  varies based on moods

**WEIGHT MANAGEMENT**

Have you ever tried to lose weight? [ ] No [ ]  Yes

Types of weight management used in the PAST:

[ ]  Restriction/Diets [ ]  Skipping Meals [ ]  Vomiting [ ]  Chewing and Spitting [ ]  Laxatives [ ]  Diet Pills [ ]  Exercise

Types of weight management used NOW:

 [ ]  Restriction/Diets [ ]  Skipping Meals [ ]  Vomiting [ ]  Chewing and Spitting

 [ ]  Laxatives [ ]  Diet Pills [ ]  Exercise

Do you believe any of these methods are successful methods of weight management for you?

 [ ]  No [ ] Yes

**EATING PATTERN**

Where do you eat most of your meals? (Check all that apply)

[ ] Self-Preparation

[ ]  Residence Hall

[ ]  Campus Convenience Store

[ ]  Student Center (please specify:\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_\_\_)

[ ]  Restaurants (please specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

[ ]  Other (please specify: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_)

How many times per day (meals + snacks) do you eat?   [ ] 1-2 [ ] 3-4 [ ] 5-6 [ ] 6-8 [ ] 9+

How many days per week do you eat “breakfast”?  [ ] 1-2 [ ] 3-4 [ ] 5-6 [ ] 6-7

What time do you generally eat your largest meal?
 [ ] morning [ ] noon [ ] mid-afternoon [ ] late afternoon [ ] evening

What meal is most frequently skipped?  [ ]  morning [ ] noon [ ] evening

Do you follow any special diet or food pattern (e.g. low‐fat, vegetarian, religious guidelines)?
 [ ] **Y**[ ] **N**
If yes, please describe:\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you usually go to bed feeling hungry? [ ] **Y**[ ] **N**

Do you usually go to bed feeling overly full? [ ] **Y**[ ] **N**

Does your eating or weight feel out of control?     [ ] **Y**[ ] **N**

Do you consciously limit or avoid any of the following foods: (Check all that apply)

|  |  |  |
| --- | --- | --- |
|   |  |  |
| 1. [ ] Red meat
 | 1. [ ] Milk
 | 1. [ ]  Sweets
 | 1. [ ] Butter/margarine
 |
| 1. [ ] Chicken
 | 1. [ ] Cheese
 | 1. [ ] Grains (i.e. rice, pasta)
 | 1. [ ] Other(s) – please list:
 |
| 1. [ ] Seafood
 | 1. [ ] Oils/dressings
 | 1. [ ] Breads
 |     |
| 1. [ ] Turkey
 | 1. [ ] Vegetables
 | 1. [ ] Fast food
 |                 |

How many servings of fruit do you eat per day?   [ ]   0 to 1       [ ]   2 to 3       [ ]   4 to 5      [ ]   > 5

(ONE SERVING = 1 tennis ball sized piece of fruit OR 1 cup chopped fruit OR ½ cup (4 oz) 100% fruit juice)

How many servings of vegetables do you eat per day? [ ]  0 to 1       [ ]  2 to 3       [ ]   4 to 5      [ ]   > 5

(ONE SERVING = ½ cup cooked vegetables OR 1 cup raw vegetables OR ½ cup (4 oz) vegetable juice)

How many servings of proteins do you eat per day
(ONE SERVING =  meat, poultry, or fish the size of a deck of cards; 2 Tablespoons nuts or nut butter, 1-2 eggs, ½ cup beans such as pinto, garbanzo, black, refried) [ ]  0 to 1       [ ]  2 to 3       [ ]   4 to 5      [ ]   > 5

How many servings of calcium-rich dairy foods do you eat per day
(ONE SERVING = 1 c (8 oz) milk, soy milk, goat’s milk or 1. c yogurt,1 ½ oz natural cheese, processed cheese, 2 c cottage cheese, 1 c pudding, 1 ½ cu ice cream or frozen yogurt)

 [ ]  0 to 1       [ ]  2 to 3       [ ]   4 to 5

How many days per week do you eat cookies, cakes, pies, candy
 [ ]  0 to 1       [ ]  2 to 3       [ ]   4 to 5      [ ]   6-7

How many days per week do you eat fast foods [ ]  0 to 1       [ ]  2 to 3       [ ]   4 to 5      [ ]   6-7

How many days per week do you eat fried foods, snack chips
 [ ]  0 to 1       [ ]  2 to 3       [ ]   4 to 5      [ ]   6-7

Q: How many days per week do you eat high fat meats and high fat dairy (e.g., hot dogs, sausage, whole milk, whole milk cheese)
 [ ]  0 to 1       [ ]  2 to 3       [ ]   4 to 5      [ ]   6-7

Q: Approximately how many cups of fluid (all beverages including milk, juice and broth-type soups) do you consume each day?

[ ]  < 2 cups (less than 16 oz)   [ ]  2 to 4 cups (16-32 oz)    [ ]  5-6 cups (40-48oz)   [ ]  7-8 cups (56-64 oz)

Do you drink caffeinated beverages (i.e. coffee, tea, soda)?   [ ] **Y**[ ]  **N**Amount daily?\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

1. **SUBSTANCE USE**
2. Do you drink alcoholic beverages?    [ ] **Y**[ ] **N**
 How many days per week do you use Beer or Wine?
	* 1. [ ]  0 to 1       [ ]  2 to 3       [ ]   4 to 5      [ ]   6-7

 How many days per week do you use Hard Liquor?
 [ ]  0 to 1       [ ]  2 to 3       [ ]   4 to 5      [ ]   6-7

Do you use Tobacco?  [ ] **Y**[ ] **N**
 [ ] Pipe or Cigar [ ] Cigarettes a Day [ ] Chewing Tobacco

Recreational Substance use may affect nutrition; Do you use any? [ ] **Y**[ ] **N**

 [ ] Marijuana [ ] Cocaine [ ] Ecstasy [ ] Acid [ ] Mushrooms

 [ ] Steroids or Pro-hormones [ ] Prescription Drugs used without Prescription \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **SUPPLEMENT USE**

Do you take any vitamin, herbal, or nutritional supplements?   [ ] **Y**[ ] **N**

Please List type and amount:

**TYPICAL DIETARY INTAKE:**

**Please fill in the following table with an example of what you *typically* eat**

|  |  |  |
| --- | --- | --- |
| **Time** | **Food Eaten** | **Where/With Whom** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

How much reluctance do you feel about coming in for nutrition counseling?

 □ No reluctance at all

 □ Very little reluctance

 □ Some reluctance

 □ Quite a bit of reluctance

□ Strong reluctance

Please explain:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What do you hope to achieve as a result of nutrition counseling?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Rate how important this change is to you (0 not at all, 10 extremely):
 [ ] 0      [ ]  1       [ ] 2      [ ]  3       [ ] 4       [ ] 5      [ ]  6       [ ] 7       [ ] 8       [ ] 9       [ ] 10

Rate how confident you are to make this change at this time:
 [ ] 0      [ ]  1       [ ] 2      [ ]  3       [ ] 4       [ ] 5      [ ]  6       [ ] 7       [ ] 8       [ ] 9       [ ] 10

What barriers, if any, stand in the way of you achieving your nutritional goals?

Do you see a psychotherapist? [ ] **Y**[ ] **N**

Do you have an interest in seeing a psychotherapist? [ ] **Y**[ ] **N**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I have seen and have access to a copy of Encompass Nutrition / Christina Scribner’s Privacy Policy Practices
 [ ] **Y**Initial\_\_\_\_\_\_[ ] **N** Initial\_\_\_\_\_\_

This information I give to the best of my knowledge:

Client’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Provider Notes:

Reviewed by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(REV. 2014)