Nutrition, Dietary and Health History Assessment

Name: _____ Date: _____

Address: _____ City: _____ State: _____ Zip Code: _____

E-mail: _____ Phone: _____

Occupation: _____ Height: _____ Age: _____ Sex: _____ Number of Children: _____

Marital Status. Please circle:

Single Married Partner Separated Divorced Widow(er)

Are you pregnant? _____

Hobbies: _____

Are you on any special diet? _____

_____

List all nutritional and/or dietary supplements you are currently using: _____

_____

_____

List current health problems for which you are being treated: _____

_____

_____

Is your job associated with potentially harmful chemicals (e.g. pesticides, radioactivity, solvents) and/or life threatening activities (e.g. firefighter, police officer, etc.)?

_____

What types of therapies have you tried for these problem(s) or to improve your health overall? Please circle:

Diet modification Live Blood Analysis/Nutritional Counseling Fasting

Vitamins/minerals Herbs Homeopathy Chiropractic Acupuncture

Conventional drugs Other: _____

Name all medications you are currently using (prescription or over-the-counter): _____

_____

_____

List all laboratory procedures performed (e.g. stool analysis, blood and urine chemistries, hair analysis): _____

_____

_____

Outcome: _____

Circle the levels of stress you are experiencing on a scale of 1 to 10 (1 being the lowest):

1 2 3 4 5 6 7 8 9 10

How would consider yourself? Please circle:

Underweight Overweight Healthy weight

Your weight today:_____lbs.

Have you had an unintentional weight loss or gain of 10 pounds or more in the last three months? _____

Are there any foods you feel / know bother you in any way? Also, list any food allergies: _____

Are you preparing your own meals? _____

List the foods you love: _____

List the foods you crave: _____

List the foods you hate: _____

List the foods you eat on a daily basis: _____

List the food/s you are avoiding for religious reasons: _____

Do you drink any of the following and if so how much per day?

Soft drinks: yes / no _____

Fruit juices: yes / no _____

Coffee: yes / no _____

Alcohol: yes / no _____

Milk: yes / no _____

Tea: yes / no _____

Water: yes / no _____

What kind of water do you drink?

Spring / Distilled / Reverse Osmosis / Well / City-Chlorinated_____

How often do you eat in restaurants? _____

How often do you eat raw foods?_____

What are your current health goals:

What are your current dietary goals:

24 Hour Dietary Recall:

Breakfast

Lunch

Dinner

Snacks

Drinks

Other: