Roswell Nutrition

Nutrition History Form

Name: _____ Date: _____

How did you hear about us? _____

SSN: _____ DOB: _____ Age: _____

Address: _____

_____

Email: _____

Home #: _____ Cell #: _____ Work #: _____

Occupation: _____

Employer: _____

Work Address: _____

_____

Emergency Contact Person: _____ Phone #: _____

Sex: _____ Race: _____ Height: _____

Current Weight: _____ Weight 6mo ago _____ Desired Weight: _____

Highest Weight: _____ Lowest Weight: _____ Easiest to Maintain: _____

How would you rate your current health status? [ ] good [ ] fair [ ] poor

What assistance are you seeking?

_____

_____

What conditions have you had or that you currently have which affect food selection?

_____

_____

Roswell Nutrition

List any family members who have had health problems, and the nature of the problem.

List supplements or medications that you take, with what they are used for and dosage.

List any special diet you have been on, along with when and how long.

How many times a day do you eat? _____

How many meals are eaten at home daily? _____

Who prepares food at home? _____

What time do you eat your first meal of the day? _____

What foods could you NOT live without? _____

What are your least favorite foods? _____

What cultural or ethnic influences affect your food selection? _____

What type of exercise do you do? _____

How often do you do each exercise? _____

How long do you do each exercise? _____

How would you rate the intensity of each exercise session? (light, moderate or heavy)

How often do you drink alcoholic beverages? _____

How much do you drink at these times? _____

Do you use tobacco? _____ What type? _____

How much? _____ For how long _____