Idaho Nutrition & Wellness Clinic LLC

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**Nutrition Intake Form**

**Referring physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**What would you like to gain from meeting with a dietitian?**

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**Have you seen a dietitian before?**

* Yes
* No

**If yes, was it within the past 12 months?**

* Yes
* No

**Have you ever been told by a doctor that you have diabetes?**

* Yes
* No

**If yes, at what age?**

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

**Have you ever had diabetic education by a Certified Diabetes Educator or a dietitian?**

* Yes
* No

**What has been your:**

**Lowest weight\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Age at lowest weight\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Highest weight\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Age at highest weight\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**What is your weight goal?**

* Weight loss
* Weight gain
* Weight maintenance

**In the last 3 months, how many times *per week* have you participated in physical activity resulting in an elevated heart rate for at least 30 continuous minute, such as jogging, swimming, rapid walking, biking, stair stepping, etc.?**

* 0
* 1
* 2
* 3
* 4
* 5
* 6
* 7
* I have a physical disability that prevents me from exercising

**If you participate in physical activity please list type(s) and duration of activity. If none, state none. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**How long have you been participating in the above stated activities?**

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**How physically active is your daily routine?**

* Not active
* Light
* Moderate
* Heavy

**Do you have any kind of physical limitations? If so, please describe:**

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**Do you do the grocery shopping?**

* Yes
* No
* Some

**Do you do the cooking at home?**

* Yes
* No
* Some

**How often do you eat out during a typical week?**

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**Where do you typically eat?**

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**Do you smoke?**

* Never
* In the past
* Currently

**Do you consume alcohol?**

* Yes drinks per week\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ type of alcohol\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* No

**Do you eat, drink, or use:**

* Protein drinks
* Appetite suppressants
* Coffee
* Decaf coffee
* Coffee creamers
* Diet soda
* Soda
* Laxatives
* Margarine or butter
* Fast foods
* Fried foods
* Chips
* Salt
* Artificial sweeteners

**Are you allergic to any foods?**

* Yes Please list\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* No

**Do you have any food intolerances/sensitivities?**

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**Are there certain foods that you avoid from your diet?**

* Yes Specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* No

**Have you ever been told by a doctor to follow a specific nutrition plan( weight loss, diabetic, low cholesterol, low salt, etc.)?**

* Yes Specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* No

**Are you currently following a nutrition plan(i.e. diabetic, gluten free, low lactose, low cholesterol, etc.)?**

* Yes Describe\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* No

**What have been some of your health challenges or obstacles that you encountered in the past?**

* Limiting sweets/desserts
* Eating too large of quantities
* Lack of motivation
* Limiting high sugar beverages
* Emotional eating( stress, upset, happy, etc.)
* Eating too fast
* Feeling overly hungry
* Lack of physical activity
* Eating when not hungry
* Food cravings
* Chewing/swallowing difficulty
* Skipping meals
* Unsure about what to eat
* Lack of appetite
* Difficulty with grocery shopping
* Difficulty with cooking
* Financial challenges
* Problems with goal setting

**Is there anything else about either your history or your current condition that you feel is important to mention?**

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**What changes are you ready to make within the next 30-60 days to improve your overall health?**

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