4. Family Medical History

Please give age, lists of any illness, or if deceased. If deceased, list cause of death and age of death.

Mother:

Father:

Siblings:

Mother's parents:

Father's parents:

5. Current Dietary Habits

Please list any specific diets that you are currently following, for example, vegan diet (no dairy, meat, fish or eggs), vegetarian, Atkins, paleo, DASH, raw, GAPS, etc:

Eating Behaviors: Briefly describe your mealtime and snack patterns:

Food Allergies and Sensitivities

☐ Wheat allergy ☐ Wheat sensitivity

☐ Dairy allergy ☐ Dairy sensitivity

Please list any other known or suspected food allergies and sensitivities: _____

Are there foods you could not give up? If so, which ones? _____

Current Food Preparation Methods

Who's doing the shopping? ☐ You ☐ Family member ☐ Friend ☐ Other

Do you eat with people or alone? ☐ People ☐ Alone

Do you eat out? ☐ Yes ☐ No

If so, how often? ☐ Once ☐ Monthly ☐ Twice monthly ☐ WeeklyDaily

What kinds of places do you eat out? _____

Do you prepare your own food? ☐ Yes ☐ No

Do you enjoy cooking? ☐ Yes ☐ No

How do you feel about food preparation and cooking? _____

_____

How much time do you spend preparing food each day? ☐ Never ☐ 1 hour ☐ 2 hours ☐ 3 hours

Food Symptoms

Please circle any of the following food symptoms that you experience on a regular basis:

☐ Stomachaches ☐ Burping ☐ Itching
☐ Sinus ☐ Flatulence ☐ Flushing
☐ Fatigue ☐ Bloating

6. Diet History

Were you breastfed, and if so, until what age? ☐ Yes ☐ No Until age:_____

Were you fed formula as a baby? ☐ Yes ☐ No

Did you experience ear infections as a child? ☐ Yes ☐ No

Use of antibiotics as a child/adult? ☐ Yes ☐ No

Please list any other childhood illnesses and the age at which they occurred: _____

_____

Please list any digestive complaints you recall having as a child (for example, stomach pains, diarrhea, constipation, gas, etc.) _____

_____

Please list any other physical complaints you recall as a child (for example, fatigue, headaches, pain):

_____

Acne as an adolescent? ☐ Nonex ☐ Mild ☐ Moderate ☐ Severe

History of fasting? ☐ Yes ☐ No

Did you experience any eating disorders during adolescence? ☐ Yes ☐ No

If so, please describe:

Briefly describe your family's eating habits and meal times (Did you eat as a family? Did you eat at the table or in front of the television? Did you fend for yourself? Were foods prepared from packages? Was there fighting at meal-time?):

7. Medications (Current and Past Use)

In the table below, please list any medications, including pharmaceuticals and antibiotics that you are currently or have previously taken.

Medication	Prescribed For	Dosage	Frequency	Dates/Duration
E.g., Wellbutrin	Depression	100mg	2/day	2010– present

13. Meaning of Food

Please describe in a few sentences what food means to you. There may be both positive and negative associations. There is no right or wrong to this answer. For example, is food important to you? Are you preoccupied with it? Does it feel nourishing? Does food cause fear or discomfort?

14. Motivation for Nutritional Change

Identify 3 reasons to improve your diet:

Identify 3 obstacles to improving your diet:

Identify 3 goals to improve your diet:

3 month goal	6 month goal	12 month goal

Identify 3 goals to improving your food preparation:

3 month goal	6 month goal	12 month goal

Food-Mood Diary and Clinician Checklist

Food/Mood Diary

Name: _____ Date: (dd/mm/yy)_____

Write down everything you eat and drink for three days, including all snacks, beverages, and water. Please include approximate amounts. Describe energy, mood or digestive responses associated with a meal/snack, and record it in the right-hand column. Use an up arrow (↑) for an increase in energy/mood, down arrow (↓) for a decrease in energy/mood, and an equal sign (=) if energy/mood is unchanged.

Time of waking:_____a.m. / p.m.

Meal	Beverages	Energy Level (↑, ↓, or =)	Mood (↑, ↓, or =)	Digestive Response (gas, bloating, gurgling, elimination, etc.)
Breakfast (Time:_____)				
Snacks (Time:_____)				
Lunch (Time:_____)				
Snacks (Time:_____)				
Dinner (Time:_____)				
Snacks (Time:_____)				