



Lifestyle Management Form 5.1

Client Assessment Questionnaire

DEMOGRAPHIC DATA

Name _____ Date: _____
 Address _____ Home telephone: _____
 _____ Cell telephone: _____
 Fax: _____ Email _____
 Sex: _____ Age: _____ Birthdate _____ Height _____ Weight _____

HEALTH HISTORY

1. What medical concerns (e.g., pregnancy), if any, do you have at the present time? none

2. Indicate if you have had blood relatives with any of the following problems:

| | | | | | |
|------------------|------------------------------|-----------------------------|---------------------|------------------------------|-----------------------------|
| Cancer | <input type="checkbox"/> yes | <input type="checkbox"/> no | High blood pressure | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| Diabetes | <input type="checkbox"/> yes | <input type="checkbox"/> no | Osteoporosis | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| Heart disease | <input type="checkbox"/> yes | <input type="checkbox"/> no | Thyroid disorder | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| High cholesterol | <input type="checkbox"/> yes | <input type="checkbox"/> no | | | |

3. Do you have complaints about any of the following?

| | | |
|-----------------------------|--------------------|------------------------------|
| _____ Appetite | _____ Constipation | _____ Menstrual difficulties |
| _____ Bleeding gums | _____ Diarrhea | _____ Seeing in dim light |
| _____ Bruising | _____ Edema | _____ Sudden weight change |
| _____ Chewing or swallowing | _____ Indigestion | _____ Stress |

4. Do you use tobacco in any way? yes no
 How much? _____
 Did you recently stop smoking? yes no

5. Do you enjoy physical activity? yes no Explain _____

6. List any food allergies or intolerances.



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DRUG HISTORY

List any prescribed, over-the-counter, herbal, or vitamin/mineral supplements you take.

DIET HISTORY

1. Do you follow a special dietary plan, such as, low cholesterol, kosher, vegetarian?

2. Have you ever followed a special diet? _____ Explain _____
3. Do you have any problems purchasing foods that you want to buy? _____
4. Are there certain foods that you do not eat? _____
5. Do you eat at regular times each day? yes no How often? _____
6. Identify any foods you particularly like. _____
7. Do you drink alcohol? Yes no How often? _____
8. What change would you like to make?
 - Improve my eating habits
 - Learn to manage my weight
 - Other _____
 - Improve my activity level
 - Improve my cholesterol/triglyceride levels
9. Please add any additional information you feel may be relevant to understanding your nutritional health. _____
10. In order to tailor your counseling experience to your needs, it would be useful to know your expectations. Please check one of the following to indicate the amount of structure you believe meets your needs:
 - Tell me exactly what to eat for all my meals and snacks. I want a detailed food plan.* Example: ½ cup oatmeal, 1 cup skim milk, 6 oz. orange juice, 1 slice whole wheat toast, 1 teaspoon margarine
 - I want a lot of structure but freedom to select foods. I want to use the exchange system.* Example: 1 milk, 2 starch, 1 fruit, and 1 fat exchange
 - I want some structure and freedom to select foods. I want to use a food group plan.* Example: 1 serving of dairy foods, fruits, and fat and oil group; 2 servings of grains
 - I don't want a diet. I just want to eat better. I will just set food goals.*



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SOCIOECONOMIC HISTORY

1. What is the highest level of formal education you received? _____
Other type of school _____
2. Are you employed? _____ Occupation _____
3. How many people in your household? _____ Ages? _____
4. Present marital status (circle one):
Single Married Divorced Widowed Separated Engaged
5. Do you have a refrigerator? _____ Stove? _____
6. Who prepares most of the meals in your home? _____ Who shops? _____
7. Do you use convenience foods daily? Yes no
8. How often do you eat out? _____ Where? _____
9. Have you made any food changes in your life you feel good about? yes no
10. Who could support and encourage you to make these changes? _____

EDUCATION INTERESTS

What information would you like from your counselor?

- | | | |
|--|--|---|
| <input type="checkbox"/> Supermarket shopping tour | <input type="checkbox"/> Eating out | <input type="checkbox"/> Exercise |
| <input type="checkbox"/> Weight management | <input type="checkbox"/> Portion size | <input type="checkbox"/> Alcohol calories |
| <input type="checkbox"/> Healthy food preparation | <input type="checkbox"/> Eating less fat | <input type="checkbox"/> Meal planning |
| <input type="checkbox"/> Fiber | <input type="checkbox"/> Walking program | <input type="checkbox"/> Snack foods |
| <input type="checkbox"/> Food labels | <input type="checkbox"/> Other _____ | |

Thank you for your willingness to share this information and to take part in the Nutrition Clinic. We look forward to working with you to make lifestyle changes in order to meet your food and fitness objectives.