# Jackie Klein Nutrition

## Physical Activity and Nutrition Appraisal

Please complete this nutrition assessment form and bring to your first session. Completing this form prior to our appointment will save time during the session and allow us to maximize our time together.
Please call with any questions 973.439.9355.

**Name** _____**Date**_____
**Address** _____ **City**_____ **State** _____ **Zip**_____
**Phone** (H) _____(W)_____ **Email**_____
**Birthdate**_____ **Age** _____**Sex** _____ **Height** _____ **Weight** _____

**Marital Status:** (circle one) Married Single Divorced Widowed Separated

**Reason for seeking nutrition counseling**:_____
_____

**List doctors/nutritionists seen for this condition:** _____
_____

**What goals do you hope to achieve as a result of nutrition counseling?** _____
_____
_____

**Where do you get most of your nutrition information?** _____
_____
_____

**List all the diets you have tried including commercial diet programs, diets written about in books, and those that you have developed yourself and indicate your age at the time. Give a brief description of the dieting technique involved.**

Book title, diet or program Your age Brief description
_____
_____
_____
_____

**Weight History**
Low weight: _____ age _____
High weight: _____ age _____
Usual weight: _____

**Occupation** _____

**How would you rate your daily stress level (check one):**

☐ *Not stressed* ☐ *Mildly stressed* ☐ *Very Stressed*

**Current Prescribed Medications:** _____
_____

**Do you take OTC Drug?** Yes / No **What kind and how often?**_____
_____

**Vitamin/mineral Supplements:** _____
**(brand/amount)** _____

**Chronic Medical Conditions**: _____

**Injuries/Surgeries (when/why):** _____
_____

**Allergies**: _____

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**Family Medical History**
**Does or has anyone in your family have/had any of the following?**

Heart Disease _____ Disordered Eating_____
Diabetes_____ Depression_____
Hypertension_____ Digestive Disorders_____

**Do you or have you experienced any of the following?**

| | | | |
|---|---|---|---|
| Hair loss | yes / no | Crave Sugar | yes / no |
| Dry skin | yes / no | Esophageal reflux | yes / no |
| Dizziness | yes / no | Stomach aches | yes / no |
| Fatigue | yes / no | Constipation | yes / no |
| Fainting spells | yes / no | Diarrhea | yes / no |
| Headaches | yes / no | Bloating/Gas | yes / no |
| Hypoglycemia | yes / no | Cold intolerance | yes / no |
| Sleep disturbance | yes / no | Irregular menses | yes / no |
| Acne | yes / no | Abnormal lab values | yes / no |

**Exercise History**

**Do you exercise***?* Yes / No

| Type | Frequency | Duration |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

**How long have you been on this exercise program**? _____

**How do you feel about your weight/body?** _____
_____

**Eating behavior**

**Do you eat breakfast on a daily basis? _____**

**How many meals do you eat per day? _____**

**Do you eat out or cook home most of the time? _____**

**Who cooks/plans your meals? _____**
**_____**

**Do you eat fruits and vegetables daily? _____**

**How much water do you drink daily? _____**

**What changes have you made in your diet in the past?_____**
**_____**

**Check all that apply:**

☐ ***Drink Alcoholic Beverages*** ***How often_____***

☐ ***Drink caffeine*** ***How much_____***

☐ ***Smoke or use tobacco products*** ***How much_____***

**Spouse/Parent: _____ Phone:_____**

**Person to contact in case of emergency: _____**

**How were you referred to this office: _____**