client overview

DEMOGRAPHIC DATA

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

HEALTH HISTORY

1. What medical concerns (e.g., pregnancy), if any, do you have at the present time?

_____

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

Cancer	☐ yes	☐ no	High blood pressure	☐ yes	☐ no
Diabetes	☐ yes	☐ no	Osteoporosis	☐ yes	☐ no
Heart disease	☐ yes	☐ no	Thyroid disorder	☐ yes	☐ no
High cholesterol	☐ yes	☐ 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.

_____

_____

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.*