Name:

Age:

Occupation (what are you doing in life and are how do you feel about it?):

Who do you live with? How many adults/children? Pets?

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**Purpose of our Consult-** Tell me about why we are meeting. What do you feel is the primary purpose?

**Medical History-** Please list/describe any medical diagnoses, procedures, or surgeries I should be aware of during our work together.

Please list your current medications & supplement dosages:

Please list/describe any mental health concerns should I be aware of (i.e. depression, anxiety, OCD, PTSD)? Are you seeing a counselor, therapist, psychologist?

If applicable, have there been any inconsistencies with your menstrual cycle? If yes, please describe.

Have you ever worked with a dietitian/nutritionist? If yes, tell me about your experience.

**Lifestyle**

How many hours of sleep do you average a night? Do you feel rested during the day?

Do you smoke? If so, what form (cigarette, vape, chew) and how often (ex. 1 pack/week)?

Do you drink alcohol? If so, how much per day? Per week?

Rate your current level of stress on a scale of 0-10 (0=none, 10=extreme):

**Exercise and Activity**

Have you ever had a consistent exercise routine?

If yes, tell me about your past exercise habits/relationship to exercise:

Tell me about your current exercise habits/relationship to exercise:

**Digestive Health**

Have you ever received a gastrointestinal (GI) diagnoses? If yes, please describe

**Gastrointestinal symptoms:**

On a scale of 1-10 (10 = terrible, 0=non-existent) please state a number that identifies the level intensity of the following symptoms:

Gas 1 2 3 4 5 6 7 8 9 10 Bloating 1 2 3 4 5 6 7 8 9 10

Nausea 1 2 3 4 5 6 7 8 9 10 Diarrhea 1 2 3 4 5 6 7 8 9 10

Constipation 1 2 3 4 5 6 7 8 9 10 Abdominal Pain 1 2 3 4 5 6 7 8 9 10

Reflux/ (GERD) 1 2 3 4 5 6 7 8 9 10 Incomplete emptying 1 2 3 4 5 6 7 8 9 10

Did you have any GI issues as child or adolescent? If yes, please describe

Do you have any food allergies or intolerances? If yes, please describe

Do you have any current dental problems?

**Relevant Family History**

Please share with me any family dynamics you feel are important for me to know/understand.

What was food like in your house growing up? What is it like now? Does anyone in your family have a history of dieting, disordered eating, or eating disorders? Other chronic illnesses?

**Food & Nutrition**

If relevant, tell me about your dieting and/or your eating disorder history.

**Eating Patterns**

How many meals a day do you eat?

Do you skip meals? If yes, which ones do you skip and why?

What are your snacking habits (i.e. frequency, time of day, foods you choose)?

When you feel overwhelmed or life gets busy, do you neglect your eating habits? If yes, please describe.

Do you feel that your life/schedule conflicts with nourishing your body in the way you’d like to? If yes, please describe.

Do you eat and multi-task (i.e. read, watch TV, drive)? If yes, please describe:

Where do you eat your meals?

Do you feel you eat particularly fast or slow? Please describe:

Do you like to cook?

Who does the grocery shopping?

Who prepares the food at home?

Please list the usual time and typical daily intake for each meal:

Breakfast:

Lunch:

Dinner:

Snacks:

What foods do you love?

What foods do you dislike?

Are there any foods that you fear or feel like binge foods for you?

Are there any foods that feel “safe” to you?

Does your diet have a lot of variety or does it tend to be the same from day to day?

**Weight- You may leave blank if you prefer if it feels uncomfortable, or, we can discuss it in session together.**

Height:

Current weight:

Average weight. for the past 2 to 3 years?

Weight you feel most comfortable When were you last at that weight?

Highest adult weight? Age:

Lowest adult weight? Age:

*If applicable*, pre-pregnancy weight? How much weight did you gain with pregnancy?

Have you lost or gained weight recently?

How much? Time frame?

Do you weigh yourself currently? If yes, how frequently?

Please circle how you currently feel about your body.

strongly dislike dislike slightly satisfied satisfied very satisfied

**Working together**

What do you hope to accomplish through our visits together?

Please feel free to share any additional information here.