

Hope Traditional Wellness

Certified Nutritional Counseling

Joel Olson CNC

General Information:

Name: _____ Today's Date: _____

Occupation: _____

Age: _____ Date of Birth: _____ Gender: _____

Reason for Appointment: _____

Primary Care Provider: _____

Address/Phone: _____

Medical History:

Height: _____ Current Weight: _____

Do you drink alcohol? Yes No Number of drinks per week: _____

Do you smoke cigarettes? Yes No Amount per day: _____

How long have you smoked? _____ If you quit smoking, when? _____

Do you use drugs? Yes No Explain: _____

List any medications you are currently taking or have taken in the last year:

1. _____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

7. _____ 8. _____

9. _____ 10. _____

Are you currently taking any food or nutritional/herbal supplements? Yes No

If yes, please specify: _____

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Please indicate whether you or a family member have/had any of the following conditions:

| Disease/Condition | Self | Family | Relationship | Treatment |
|------------------------|-------|--------|--------------|-----------|
| Asthma | _____ | _____ | _____ | _____ |
| Cancer | _____ | _____ | _____ | _____ |
| Cardiovascular Disease | _____ | _____ | _____ | _____ |
| Diabetes | _____ | _____ | _____ | _____ |
| Drug Dependency | _____ | _____ | _____ | _____ |
| Eating Disorder | _____ | _____ | _____ | _____ |
| Food Allergies | _____ | _____ | _____ | _____ |
| Food Intolerances | _____ | _____ | _____ | _____ |
| Kidney Disease | _____ | _____ | _____ | _____ |
| High Cholesterol | _____ | _____ | _____ | _____ |
| High Blood Pressure | _____ | _____ | _____ | _____ |
| Intestinal Problems | _____ | _____ | _____ | _____ |
| Menstrual Problems | _____ | _____ | _____ | _____ |
| Osteoporosis | _____ | _____ | _____ | _____ |
| Other _____ | _____ | _____ | _____ | _____ |

Are you currently being treated for any medical conditions? Yes No
If yes, please specify: _____

Have you ever been advised by your physician to follow a special diet? Yes No
If yes, please specify: _____

Are you currently following that diet? ___ Yes ___ No
If not, why? If yes, what changes have you made? _____

Weight/Dieting History:

Have you tried to lose weight before? ___ Yes ___ No
How many times? _____ Age of first attempt: _____ years
What did you do? _____
Why did you go on that diet? _____

Do you experience periods during which you eat uncontrollably? ___ Yes ___ No
If yes, how often? _____

Is this followed by:
___ Vomiting How often? _
___ Laxative use
___ Excessive exercising
___ Negative emotions

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Weight/Dieting History, Continued:

Have you ever been diagnosed with an eating disorder? Yes No

If yes, please explain: _____

Are you currently or have you ever received treatment? Yes No

If yes, please explain: _____

Do you currently exercise for weight control? Yes No

Please explain: _____

Exercise History:

Do you exercise? Yes No

Please explain: _____

If so, how often? Daily Every Other Day Twice Per Week One Per Week Rarely

Type of Exercise? Walking Areobics Dance Running Cycling Team Sports

Yoga Weight Lifting Swimming Tennis Racket Ball

Rowing Hiking Rollerblade Pilates Tai Chi

Other, Please explain: _____

Eating Habits:

Do you skip meals? Yes No

How many days per week do you eat:

Breakfast: _____ Lunch: _____ Dinner: _____

Do you snack? Yes No

If so, when? _____

Do you buy or pack your lunches?

Buy # days per week: _____ Pack # days per week: _____

Do you eat out? Yes No

How many meals per week? _____

What restaurants do you usually choose?

1. _____ 4. _____ 7. _____

2. _____ 5. _____ 8. _____

3. _____ 6. _____ 9. _____

Who usually prepares the food at home? _____

Who does the grocery shopping? _____

Please specify how many of the follow you drink per week:

_____ alcohol diet soft drinks regular soft drinks

_____ caffeinated coffee fruit juice regular tea

_____ decaf coffee green tea sports drinks

_____ diet drinks/aids herbal tea water

Please indicate any beverages that are not listed that you consume regularly _____

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Eating Habits, Continued:

What foods do you crave? _____

What foods do you avoid? _____

Why? _____

Do you snack during the day? Yes No If yes, please describe _____

Do you have good energy levels? Yes No Inconsistent Does napping help? Yes No

Can you attribute low energy to anything in particular? Yes No

If yes, please specify _____

Do you consider yourself Underweight Overweight Just Right

Sleep Time you normally go to bed _____ Fall asleep _____ Awaken for the day _____

How many hours of sleep do you need to feel rested? _____ How many do you get? _____

Goals/Expectations

Do you want to change your eating habits? _____ Yes _____ No

Why? _____

Did you have any expectations from coming to see the nutritionist today? _____ Yes _____ No

Please explain: _____

***It is helpful for our Nutritionists to have ample time to review your information. If possible, please send your paperwork at least one day prior to your scheduled appointment. Thank You!