NUTRITION/HEALTH HISTORY

IMPORTANT: Please complete this information and mail or bring it to our initial visit.

Verna Groger
4511 NW 16 Place
Gainesville, Fl 32605 *(All information is confidential.)*

Personal History

Name: ______________________ DOB: ________________

Address: _________________________________ City________ Zip________

Best Phone: ______________________ 2nd Phone_________________________

E-mail: ___________________________________

Physician Name: _________________________ Physician Phone:_________________

Occupation: ______________________ Weekly hours: ____________ N/A_______

Health History

1. Do you have any medical problems/concerns? No_____ Yes_____ please describes:

____

2. Are you under a doctor's care for any of the following conditions?

Diabetes_______ Heart Disease _______ Blood Pressure_______

Cancer_______ High Triglycerides or Cholesterol_______ Overweight_______

Osteoporosis or decrease in bone density_______ Please describe any other conditions:

____

____

____

3. Family history of: Diabetes_______ Heart disease ________

High Blood Pressure_______ Cancer_______ type? __________________________

who?______________________ Other: ____________________________________

4. The level of stress you are experiencing on a scale of 1 to 10: ________ Sources of stress____

5. Have you had any recent lab results that were abnormal? No______ Yes______

List which labs were not normal (or include a copy of current lab results): __________

____

DAILY FOOD RECORD

Record the times, foods and amounts on a typical day plus weekend variations.

Breakfast: I usually eat at ____o'clock or I skip breakfast ____days/week.

A breakfast I often eat is:

A breakfast I sometimes eat:

On weekends I often have:

Mid-morning Snack: I usually eat at ____ o'clock or I don't eat this snack ____days/week.

The snacks I frequently eat are:

On weekends I may have:

Lunch: I usually eat at ____o’clock or I skip lunch ____days/week.

A lunch I often eat is:

A lunch I sometimes eat:

On weekends I often eat:

Afternoon snack: I usually eat at ____ o’clock or I don’t eat this snack ____days/week.

The snacks I frequently eat are:

On weekends:

Evening Meal: I usually eat at ____o’clock or I skip supper ____days/week.

A meal I often eat is:

A meal I sometimes eat is:

On weekends I often have:

Evening Snack: I usually eat at ____ o’clock or I don’t eat this snack ____days/week.

Snacks I frequently eat:

On weekends:

(If you do not drink alcohol, skip the next question.)

Type and number of alcoholic drinks you consume.

Alcoholic Beverage	***Daily Servings*** *(5oz wine or 12oz beer or 1.5oz spirits)*
Mixed drinks	
Beer	Regular ________ “Light” ________
Wine	
Other	

Beverages on a daily basis

Beverage	**Serving size** (ounces or cups)	**How many per day?**
Fruit Juice		
Coffee with ___cream or half & half ___ whole milk ___ nonfat milk ___ sugar		
Hot Tea with: cream or half & half ___ whole milk ___ nonfat milk ___ sugar ___ honey ___		
Regular soda ____ Diet soda _____		
Coffee drinks (Starbucks or other sweetened		
Iced Tea or Iced Coffee bottled____ home-brewed _______		
Water		
Other		

What are some food/drinks you avoid in order to stay healthy?

Do you eat/drink anything for special health benefits?

Do you have specific nutritional issues or questions that you'd like me to address?

How many days per week are you willing to record your diet and activity? *(Every day is best.)*

1 time weekly ______ 3 days weekly ______ 5 days weekly ______ every day _____

How committed are you to making changes to improve your weight and health?

Very committed ______ Somewhat ______ Not ______ Ask me again later _____

Age: _______ **Height:** ________ **Current Weight:** ________ **Goal Weight:** ________

1. You think you are: Overweight_____ Underweight_____ Just right_____
2. Have you tried to lose weight in the past? No_____ Yes, how many times______
3. If yes, has a particular method of diet worked for you? ___________________________

   How many pounds? _______
4. If you regained, check: All____ Some_____ None (I've kept it all off)______
5. Describe your current meal/diet plan or way of eating.
6. How often do you feel your eating is "on track"? Never_____ 25%_____
   50%_____ 75%_____ 90-100%_____
7. Describe your appetite: Always hungry_____ Normal_____ Poor_____
8. Do you skip meals? No____ Yes____ Which Meals? Breakfast______
   Lunch______ Supper______
9. How often do you feel "stuffed" after eating?

10. Do you ever feel out of control when eating? No___ Yes___

How often? Please describe.

11. What prevents you from reaching your health goals? Check all that apply:

Unsure of how to reach them_____ Cravings_____ Binges_____

Busy schedule_____ Budget______ Lack of support______

Work environment______ Hate to exercise_____

Other reasons:

12. Who grocery shops in your household? _______ How often? _______

13. Who cooks or prepares meals?

14. Please indicate dine-in/take-out/fast-food weekly.

	Times per Week	***Dine In or Take Out***	***Restaurants or types of Meals/Snacks***
Breakfast			
Lunch			
Dinner			
Snacks (include coffee)			

15. Digestive Problems? None_____ Constipation____ Diarrhea____ Gas_____ Bloating_____ Other:

16. Medications you currently take with dose and for what purpose:

1. ____

2. ____

17. Supplements with dose and for what purpose: **(Please bring bottles to your visit.)**

1. ____

2. ____

18. Do you have any food intolerances? No_____ Yes_____ (please list)

____

19. Do you have any allergies? (food, medication, environmental)? No_____ Yes______

List: ____

Has your doctor made this diagnosis? No_____ Yes_____ Are you being treated? No_____ Yes_____

20. Do you smoke? No_____ Yes_____ Amount?________

Activity and Exercise

1. Do you exercise? Never_____ Sometimes_____ Daily_____

Walking_____ Biking_____ Swimming_____ Aerobics_____ Free weights_____ Machines_____

2. Do you belong to a gym? No_____ Yes_____ If yes, how many visits/week?_______
3. Do you practice Yoga, Tai Chi, or Chi Kung? If yes, circle any you do regularly.
4. Other Physical Activity: ____

____

How often? ____________________ How long? __________________________________

5. Do you have trouble sleeping? No______ Yes______ If yes, frequency and degree plus coping strategies.

   ____

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