North Georgia NUTRITION & WELLNESS

Date: _____

Name: _____ Sex: □M □F Age: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

## Medical History

1. Are you currently being treated for any medical conditions? □ Yes □ No If yes, please describe:

Please list any medications you currently take:

2. Have you had any blood work done in the last year? □ Yes □ No
Results: □ Normal □ Abnormal
If abnormal results, please describe (e.g., high blood sugar, high triglycerides, high cholesterol, etc.):

3. Have you been instructed by your doctor or any other health professional to follow a specific diet?
If so, what diet instructions have you been given?

**Weight History**

2. Current weight _____ pounds, height _____ inches, BMI _____

3. Desired weight _____ pounds

4. Recent weight gain _____ pounds, weight lost _____ pounds

5. Weight management programs you have tried in the past _____
_____
Pros of program: _____
Cons of program: _____

**Physical Activity and Exercise History**

1. Describe your current level of activity daily? _____

**2.** Do you exercise regularly? _____ If yes, how often, duration and intensity of workout?

**Lifestyle and Eating Habits**

1. Are you on a special diet? □ Yes □ No Type: _____
(e.g., low cholesterol, low sodium, low carbohydrate, high protein, low fat, etc.)

2. Are you currently avoiding any particular foods? □ Yes □ No If yes, please list: (e.g., red meat, dairy, eggs, nuts)

3. List all foods to which you are allergic or intolerant: (e.g., dairy, seafood, peanuts, wheat)

4. Are you a vegetarian? □ Yes □ No If yes, what type do you practice?
□ No meat, dairy, or eggs
□ No meat only
□ Other: _____

5. Do you eat 3 meals per day regularly? □ Yes □ No More? _____
Snacks? □ Yes □ No Types of snack choices:

6. Do you skip meals? □ Yes □ No If yes, which meals do you skip □ breakfast □ lunch □ dinner
and for what reason (e.g., lack of time)?
Reason for skipping meals:
_____

7. How often do you eat out? ___ times/week. What are some of your favorite restaurants?

8. How often do you eat fast food? ___ times/week. What fast food restaurants do you frequent?

9. Do you eat most of your meals with someone (e.g., a roommate, team member, family members)?
□ Yes □ No With whom?

12. Who prepares most of your meals?

13. Where do you eat most of your meals?
□ at home
□ school
□ cafeteria
□ restaurants
□ other: _____

14. List some of your favorite foods: _____
15. List foods you dislike_____

16. Do you eat most of your meals in less than 20 minutes?

17. Do you usually do other activities while you eat?

18. Do you consider yourself to be a stress eater?

19. What types of beverages do you consume at meals?

20. How many caffeinated beverages do you consume daily?
Sodas: _____ decaf sodas: _____
Coffee: _____ decaf coffee: _____
Tea/iced tea: _____ decaf or herb tea/iced tea: _____

21. How many cups of water do you consume daily?

22. Do you drink alcoholic beverages? □ Yes □ No Type and average consumption per week:

23. Describe your methods of food prep used most often
_____

22. Do you take vitamin/mineral supplements? (e.g., iron, calcium, multivitamin) □ Yes □ No
Please list the dosage of all supplements you currently use: (e.g., Calcium 500 mg 1x/day)

**Personal Nutrition Goals**

1. Do you have any personal nutrition goals? If so, please list below:

2. How confident are you in making lifestyle changes in order to meet your goals?

3. List any areas of confusion with nutrition and wellness you would like answered:

**Food History (**Please list everything you eat and amounts)

Weekday:

Breakfast:

Lunch:

Supper:

Snacks:

Weekend:

Breakfast:

Lunch:

Supper:

Snacks:

Please print out this form, fill it out and email or fax back to Leslie Davis before your initial consult.

leslie@ngnutritionwellness.com
Fax: 770-965-7845 (call before you fax please)