Patient Nutrition Intake

Date: _____

Name: _____ Date of birth: _____

Reason for visit: _____

Personal History

Health Concerns

What are your main health concerns? (Describe in detail, including the severity of the symptoms):

1. When did you first experience these concerns?

2. How have you dealt with these concerns in the past?

3. Have you experienced any success with these approaches?

History

1. Have you lived or traveled outside of the United States? If so, when and where?

2. Have you or your family recently experienced any major life changes?

3. How often did you take antibiotics in infancy/childhood?

4. How often have you taken antibiotics as an adult?

5. List all vitamins, minerals, herbs and nutritional supplements you are now taking:

6. Have any other family members had similar problems (describe)?

Nutritional History

1. Do you have any known food allergies? ☐ Yes ☐ No
   Please list and explain effect:

2. Foods you dislike:

3. Foods you crave:

4. Are there any foods that you avoid because of the way they make you feel? If yes, please name the food(s) and the symptom(s):

5. Do you have symptoms immediately after eating like bloating, gas, nausea, runny nose, sneezing or hives? If so, please explain:

6. Are you aware of any delayed symptoms after eating certain foods such as fatigue, rashes, muscle aches, sinus congestion, etc.? If so, please explain:

7. Which of the following foods do you consume regularly?

   ☐ Soda ☐ Diet soda ☐ Refined sugar ☐ Alcohol ☐ Gluten (wheat, rye, barley)
   ☐ Dairy (milk, cheese, yogurt) ☐ Fast food ☐ Coffee

8. Are you currently on a special diet?

   ☐ Ketogenic ☐ Low FODMAP ☐ Refined sugar-free ☐ Diabetic ☐ Paleo ☐ AIP
   ☐ Gluten-free ☐ Dairy restricted or dairy-free ☐ Vegetarian
   ☐ Other (Please Describe): _____

9. What percentage of your meals are home-cooked? _____

10. At which stores do you shop for food?

11. Who does the shopping/cooking? ☐ Myself ☐ Roommate/Partner ☐ Other: _____

12. Do you like to cook? ☐ Yes ☐ No

13. How many times per week do you eat outside of home and where?

	Frequency	Locations(s)
14. Breakfast	_____	_____
15. Lunch	_____	_____
16. Dinner	_____	_____

17. Is there anything else we should know about your current diet, history or relationship to food?

Lifestyle History

1. Have you had periods of eating junk food, binge eating or dieting? List any known diet that you have been on for a significant amount of time:

2. Have you used or abused alcohol, drugs, meds, tobacco or caffeine? Do you still?

3. How do you handle stress? Do you currently use any stress management techniques?

4. Describe your sleep patterns. Can you get to sleep easily? Can you stay asleep? How many hours do you average per night?

On a scale of 1-10 (1=low, 10=high), rate the following:
Your average level of stress: _____
Your level of energy: _____
Does your pain or physical symptoms increase the more stressed you are? ☐ Yes ☐ No

Living Situation

☐ Alone ☐ Partner ☐ Roommates

☐ Other:_____

Physical Activity

Do you exercise? ☐ Yes ☐ No

If yes, what types?
☐ Cardio ☐ Weights ☐ Yoga ☐ Home exercises

☐ Other: _____

Frequency and duration of exercise:

If not, explain contributing factors:

Gastrointestinal Health

Which of the following do you experience regularly?

☐ Gas ☐ Bloating ☐ Constipation ☐ Diarrhea ☐ Heartburn ☐ Nausea or vomiting

Bowel Movement Frequency

☐ 1-3 times per day ☐ More than 3 times per day ☐ Not regularly every day

Bowel Movement Consistency

☐ soft & well -formed ☐ often float ☐ difficult to pass
☐ diarrhea ☐ thin, long or narrow ☐ small and hard ☐ loose but not watery
☐ alternating between hard and loose

Bowel Movement Color

☐ Medium brown ☐ Variable ☐ Very dark or black ☐ Yellow, light brown
☐ Greenish ☐ Chalky colored ☐ Blood is visible ☐ Greasy, shiny

Mental Health Status

1. How are your moods in general? Do you experience more than you would like of anxiety? Depression? Anger?

2. At what point in your life did you feel best? Why?

Other

1. Do you think family and friends will be supportive of you making health and lifestyle changes to improve your quality of life? Explain, if no.

2. Who in your family or on your health care team will be most supportive of you making dietary change?

3. Please describe any other information you think would be useful in helping to address your health concern(s):

4. What are your health goals and aspirations?

Diet History

Please provide a 3-day food history, including 2 weekdays and 1 weekend day. If you're experiencing pain or gastrointestinal issues, include any symptoms that you experience, and note the times. Be specific and try not to change what you eat through the process. Include beverages and any snacks.

Note: if time does not allow you to fill in the form prior to appointment, we will cover off-form in session.

DAY 1

Time	Food Eaten	Symptoms

How much water did you drink today?

What other fluids and amounts did you drink today?

PLACE PATIENT LABEL HERE

DAY 2

Time	Food Eaten	Symptoms

How much water did you drink today?

What other fluids and amounts did you drink today?

PLACE PATIENT LABEL HERE

DAY 3

Time	Food Eaten	Symptoms

How much water did you drink today?

What other fluids and amounts did you drink today?

PLACE PATIENT LABEL HERE