Vita Nutrition Services

Your Dietitian will be going over this form with you at your very first visit. Feel free to bring a medication list as well as any other past medical history, questions, medical testing paperwork and blood work. We look forward to meeting and working along side of you at your initial visit!

New Patient Nutrition Assessment Form:

First Name _____Middle Initial:____ Last Name_____
Birth Date _____/_____/_____ Age _____
Height: ___′ ____ ″ Weight: _____ BMI: _____ Indicates: _____Sex: _____

Recent Weight Changes?_____ Weight History: _____

Are you pregnant? Yes No N/A Due Date_____

I would like to visit with the dietitian, today because...
_____
_____
_____
My food and nutrition-related goals are...
_____
_____
_____
My overall, health goals are...
_____
_____
_____

The biggest challenge(s) to reaching my nutrition goals is/are:
_____
_____
_____

In the past, I have tried the following techniques, diets, behaviors, etc. to reach my nutrition goals...
_____
_____
_____

On a scale of 1 (not willing) to 5 (very willing), please indicate your readiness/willingness to do the following:

To improve your health, how ready/willing are you to...	1	2	3	4	5
Significantly modify your diet					
Take nutritional supplements each day					
Keep a record of everything you eat each day					
Modify your lifestyle (ex: work demands, sleep habits, physical activity)					
Practice relaxation techniques					
Engage in regular exercise/physical activity					
Have periodic lab tests to assess your progress					

MEDICATION, SUPPLEMENT, AND ANTIBIOTIC INTAKE: Please provide the names of medications, supplements, and/or antibiotics that you are taking:

Medication/Supplement/ Antibiotic Dose	Units	Frequency	Start Date	Stop Date
Example:One-a-Day (brand) Men's Multivitamin	1200 Mg	Daily	08/12/2007	Current

PAST MEDICAL AND SURGICAL HISTORY

Allergies:		Autoimmune Condition	
Cancer		Chronic Fatigue Syndrome	
Crohn's Ulcerative Colitis		Depression	
Diabetes		Fibromyalgia	
Food Allergies		Gallbladder Disease	
Gout		Heart Disease	
High Blood Pressure		High Cholesterol/Triglycerides	
Irritable Bowel Syndrome		Kidney Disease	
Liver Disease		Osteoporosis	
Polycystic Ovarian Syndrome		Thyroid Disease	
Additional Information:			

Lifestyle

Physical Activity: please describe your physical activity.

Activity	Type/Intensity (low-moderate-high)	# Days per week	Duration (minutes)
Stretching/Yoga			
Cardio/Aerobics (walking, jogging, biking, etc.)			
Strength-training (weight lifting, Pilates, some yoga)			
Sports or Leisure			
Other (specify/describe)			

Does anything limit you from being physically active? _____
Indicate daily stressors_____
What helps you to cope with stress?_____
On average, how many hours of sleep do you get? Weekdays_____ Weekends_____
Do you smoke? Never In the past Currently How long?_____ Alcohol use Never In the past Currently Type/amount/frequency_____

DIGESTIVE HISTORY

Do you associate any digestive symptoms with eating certain foods? Yes/No

Please explain:_____

_____
How often do you have a bowel movement? _____
If you take laxatives, what type and/or brand and how often?
Would you describe your stools are hard, soft, or loose?
Please indicate how often you experience the following symptoms:
Heartburn: Rarely Sometimes Frequently
Gas: Rarely Sometimes Frequently
Bloating: Rarely Sometimes Frequently
Stomach Pain: Rarely Sometimes Frequently Nausea/Vomiting: Rarely Sometimes Frequently Diarrhea Constipation: Rarely Sometimes Frequently

DIET HISTORY

Do you follow any special diet or have diet restrictions or limitations for any reason (health, cultural, religious or other)?
Please list any food allergies, sensitivities or intolerances?
Who prepares the majority of your meals?
Who shops for food?
Do you find cooking difficult?
What foods do you crave?
What foods do you not like?

Daily Food Recall

Breakfast: Time Eaten _____O'clock

Food Eaten: _____

How I Felt After Eating: _____

Snacks: Time Eaten_____ O'clock

Food Eaten: _____

How I Felt After Eating: _____

Lunch: Time Eaten_____ O'clock

Food Eaten: _____

How I Felt After Eating: _____

Snacks: Time Eaten_____ O'clock

Food Eaten: _____

How I Felt After Eating: _____

Dinner: Time Eaten_____ O'clock

Food Eaten: _____

How I Felt After Eating: _____

Snacks: Time Eaten_____ O'clock

Food Eaten: _____

How I Felt After Eating: _____

Nutritional Target Ranges

Kcal Range (Maintenance) _____-_____ based on _____

Kcal Range (Loss) _____-_____ based on _____

Kcal Range (Gain) _____-_____ based on _____

Protein Needs _____-_____ based on _____

Fluid Recommendations _____

Additional Notes: