



Date: _____ Name: _____ Parent's name: _____

Phone Number(s): Home: _____ Alternate: _____ work/cell

Physician(s): _____

1. Age: _____ Date of Birth: ____/____/____ Ht: ____' ____" Wt: _____

2. Grade in School: _____

3. Personal and Family Medical History:

Please place a (X) in column A if you currently have or have had any of the following health problems.

Please place a (X) in column B if any members of your immediate family (ie: parents, siblings, grandparents) have had any of the following conditions:

	A. Yourself	B. Family
1. Overweight		
2. Diabetes		
3. Hypoglycemia (Low Blood Sugar)		
4. High Blood Pressure		
5. High Cholesterol		
6. Heart Attack		
7. Stroke		
8. Bypass Surgery		
9. Angina		
10. Cancer		
11. HIV		
12. Kidney Disease		
13. Psychiatric History		
14. Orthopedic Problems (Knees & Joints)		
15. Other (Please Specify):		

4. Living Situation: *(Please circle all that apply)*
Both Parents / Joint Custody / Mother / Father / Other:

5. Who does the cooking in your household? _____ The grocery shopping? _____

6. How is the food typically prepared? *(Please circle all that apply)*
Baked / Fried / Microwaved / Grilled / Other(s): _____

7. How often, and at which meals, do you eat out during the week?
Breakfast ____ / Lunch ____ / Dinner ____ / Others _____

8. What types of restaurants do you usually frequent? *(Please circle all that apply)*
Fast Food / Salad Bar-Bufferets / Ethnic Foods / Others _____
9. How many teeth do you have? *(If age 2 and under)* _____
10. Do you have difficulty chewing or swallowing food? Yes _____ No _____
11. Do you do any regular physical exercise? Yes _____ No _____ If yes, what type? _____
How often? _____
12. Have you had any previous nutritional counseling? Yes _____ No _____
If yes, when and why? _____
13. Are there any foods you avoid for religious, health, or philosophical reasons? Yes _____ No _____
If yes, explain: _____
14. Do you have any food allergies or intolerances? Yes _____ No _____
If yes, explain: _____
15. How is your appetite? Good / Fair / Poor
16. Have you made any significant changes in your eating recently? Yes _____ No _____
If yes, explain: _____
17. Do you take vitamins, minerals, herbal, or nutritional supplements? Yes _____ No _____
If yes, please list: _____
18. Are you currently taking prescription medication? Yes _____ No _____
If yes, please list: _____
19. Has your weight changed over the past year? Yes _____ No _____
If yes, how many pounds have you gained? _____ Lost? _____
Describe any significant events in your life which influenced this: _____

20. Do you smoke? Yes _____ No _____ (Quit? _____ months _____ years)
21. Do you drink alcohol? Yes _____ No _____
If yes, what type? _____ How often? _____

If weight control is a concern for you, please answer questions 22 - 24.

22. At what weight have you felt your best, or think you would feel your best? _____

23. Have you been on weight loss diets before? Yes _____ No _____

If yes, explain: _____

24. What significant problems, if any, have you encountered with previous weight loss efforts?

25. Please fill out the food intake chart below:

INDICATE BELOW WHAT YOU EAT IN A TYPICAL DAY AND WHEN. <i>(Include Meals, Snacks, Beverages, Etc.)</i>	
BREAKFAST	
TIME:	
SNACK	
TIME:	
LUNCH	
TIME:	
SNACK	
TIME:	
DINNER	
TIME:	
SNACK	
TIME:	