Sun Health WELLNESS

Nutrition Intake Form

Date

Name (Last, First, MI) Date of Birth

Referring Physician:

What would you like to gain from meeting with a dietitian?

Have you seen a dietitian before? ☐ Yes ☐ No

If so, was it within the past 12 months? ☐ Yes ☐ No

Have you ever been told by a doctor that you have diabetes? ☐ Yes ☐ No

If yes, at what age? ☐ Type I ☐ Type II

Have you ever had diabetic education by a Certified Diabetic Educator or a dietitian? Yes ☐ No ☐

Current height: Current weight: Weight one (1) year ago:

What has been your highest non-pregnant weight? Age

What has been your lowest weight? Age

What is your weight goal? ☐ Weight loss ☐ Weight gain ☐ Weight maintenance

PHYSICAL ACTIVITY

In the last three (3) months, how many times per week have you participated in physical activity resulting in an elevated heart rate for **at least 30 continuous minutes**, such as jogging, swimming, rapid walking, biking, stair stepping, dancing, etc.?

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7

☐ I have a physical disability that prevents me from exercising

If you participate in physical activity, please list type(s) and duration of activity. If none, state none.

How long have you been participating in the above stated activities?

How physically active is your daily routine?

☐ Not Active ☐ Light ☐ Moderate ☐ Heavy

Do you have any kind of physical limitations? If so, please describe:

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NUTRITION

Do you do the grocery shopping? Yes ☐ No ☐ Some ☐

Do you do the cooking at home? Yes ☐ No ☐ Some ☐

How often do you eat out during a typical week? _____ Where do you eat at? _____

Do you consume alcohol? Yes ☐ No ☐

If yes, how often? _____

Are you allergic to any foods? Yes ☐ No ☐

If yes, please list _____

Do you have any food intolerances/sensitivities? Yes ☐ No ☐

If yes, please list _____

Are there certain foods that you avoid from your diet? Yes ☐ No ☐

If yes, please explain _____

Have you ever been told by a doctor to follow a specific nutrition plan (weight loss, diabetic, low cholesterol, etc.)? Yes ☐ No ☐

If yes, please explain _____

Are you currently following a nutrition plan (i.e. diabetic, gluten free, low lactose, low cholesterol, etc.)?

Yes ☐ No ☐

If yes, please describe _____

What have been some of your health challenges/obstacles that you encountered in the past?

- ☐ Limiting sweets/desserts
- ☐ Eating too large of quantities
- ☐ Lack of motivation
- ☐ Limiting high sugar beverages
- ☐ Emotional eating (stress, upset, happy, etc.)
- ☐ Problems with goal setting
- ☐ Eating too fast
- ☐ Feeling overly hungry
- ☐ Lack of physical activity (not seeing results)
- ☐ Eating when not hungry
- ☐ Food cravings
- ☐ Chewing/swallowing
- ☐ Skipping meals
- ☐ Unsure about what to eat
- ☐ Lack of appetite
- ☐ Difficulty with shopping
- ☐ Difficulty with cooking
- ☐ Financial challenges

What changes are you ready to make within the next 30-60 days to improve your overall health?

_____

_____

_____

_____

Name: _____ DOB: _____

FOOD AND BEVERAGE RECORD

Please write down everything that you eat and drink for three (3) consecutive days. Please include as much information as possible as this helps us in the evaluation and planning of your nutritional plan.

Date/Time	Location of meal	Food/Beverage Item	Quantity	How Hungry	Comments

Name: _____ DOB: _____

Updated: May 2015