

NUTRITION HEALTH ASSESSMENT

NAME (First, Last) _____

ADDRESS (Street, City, State, Zip Code) _____

HOME PHONE () _____

E-MAIL _____

CELL () _____

WORK () _____

Profession: _____

DATE OF BIRTH _____

Birthplace _____

HEIGHT _____

Sex _____

WEIGHT _____

What has been your average weight over the last three years? _____

What is the weight you are most comfortable at? _____

Referred By: _____ **Relationship:** _____

PRIMARY PHYSICIAN _____ **PHONE** _____

Reason for consultation: _____

Medical history

Do you have any of the following conditions? Please check all that apply.

1. Diabetes (Type I , II, or gestational) _____
2. Insulin resistance ___ Diagnosis date? _____
3. Heart disease ___ Please explain _____
4. High/low blood pressure _____
5. High cholesterol ___ High triglycerides ___
6. Overweight/obesity ___
7. Sleep apnea _____
8. GERD or reflux _____
9. Irritable bowel syndrome ___ Please explain _____
10. Diverticulosis _____
11. Stroke _____
12. Kidney disease _____
13. Cancer ___ Please explain _____
14. Mental illness ___ If yes, please explain _____
15. Eating disorder(s) or ED behaviors ___; Please explain _____

Additional concerns: _____

Mindful Nutrition Counseling

Office: 5061 North Pulaski Rd, Chicago, IL 60630

P: (773) 539-9364 * Fax: (773) 539-0039

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Do you have any food allergies or intolerances?

If yes, please explain _____

Family history

Has anyone in your family been diagnosed with any of the diseases listed above?

Medications

Please list all medications you currently take: (dosage & time of day):

Please list all vitamins/minerals or herbal supplements you currently take:

Current blood work (Please provide most recent results, if known):

Blood sugar (fasting)_____ Hemoglobin A1c____ Blood pressure:_____

Iron status_____ Thyroid (TSH):_____ Triglycerides:_____

Total cholesterol____ LDL____ HDL____ Other_____

May we contact your Primary Care Physician to obtain blood work? _____

Physical activity

How frequently do you do you exercise?

Never _____ 1-2 x/wk _____ 3-4 x/wk_____ >4 x/wk _____

Average length of time?

<30 min _____ 30-60 min _____ >60 min _____

Please indicate the type of exercise(s) that you typically do:

Describe your workout intensity below: Light_____ Moderate _____ Vigorous_____

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Eating habits

Do you follow a special diet? Please explain.

Please circle how many meals do you eat per day: 1 2 3 4 5 6 7 8

Please circle how many meals you eat per day on weekends: 1 2 3 4 5 6 7 8

Do you avoid any foods? _____

Why? _____

Do you have food cravings? _____

Do your eating habits change when stressed? _____

Who does the grocery shopping _____; How often? _____

Restaurant dining

Please circle the number of days a week do you eat away from home: 1 2 3 4 5 6 7

What meals do you typically eat away from home?

What are your favorite restaurants?

Lifestyle

Are you a smoker? ___ Yes ___ No; If yes, how many cigarettes per day? _____

Do you drink alcohol? ___ Yes ___ No; If yes, how many drinks per week? _____

Personal concerns

Would you like to change anything about your present lifestyle behavior(s)?

Do you use stress reduction techniques? ___ Yes ___ No

What techniques do you (or have you) used? How often?

What do you do for relaxation or enjoyment?

On average, how many hours of sleep do you get per day? _____

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