Name_____ Date_____

Best Contact Phone Number_____ E-mail_____

Agreement of Participation and Confidentiality

Your signature below indicates your permission and willingness to participate in the below assessments, questionnaires and interviews and *consider* the potential program or recommendations, including interviews, counseling, medical nutrition therapy, personal training sessions and subsequent dietary/nutrition/exercise/health recommendations. All information and data discussed, written, typed, or communicated will be strictly confidential between the patient and the Odom Health & Wellness healthcare team.

You agree that the information you provide in the forms, assessments and interviews is accurate and current to the best of your ability. The OHW team commits to helping you reach your goals; encouraging and motivating you to overcome obstacles; equipping you to make healthy decisions and not giving up on you or your goals.

You also acknowledge that OHW is not solely responsible for your complete healthcare and needs to understand and be made aware of any changes or concerns in your health.

Signature: _____ Date: _____

Nutrition Assessment

What is the main reason or purpose for which you are seeing the registered dietitian nutritionist?

_____

Section1: Demographic Data

Today's Date: _____ Sex: M F Age:_____ Date of Birth: _____ Height:_____ ____Current Weight:_____
Normal Weight: _____ Weight 6 Months Ago:_____

Section 2: Health History

1. List any medical conditions or diagnoses you have been treated for with prescriptions, surgery, or other medical care in the last 5 years. _____

_____

_____

2. List any seasonal allergies and/or food allergies, sensitivities or intolerances. _____

_____

3. Please list all of the following taken currently or within the last year: medications, hormone replacement therapies, antibiotics or other medically related medications or remedies. (Vitamins, minerals, nutraceuticals, etc will be asked for in a different section.)

Name/Description	Dosage/Quantity	Frequency	Start Date	Stop Date
Example: Metformin	*500mg*	*2x/day*	*1/5/2015*	*Current*

4.

✓	Please indicate if you or a blood relative have been diagnosed with or experienced any of the following conditions or symptoms.	Self or Family Member?	Specifics (Date, Explain, etc)
☐	Allergies (please specify type of allergy)		
☐	Anemia		
☐	Anxiety or Panic Attacks		
☐	Arthritis (osteoarthritis or rheumatoid)		
☐	Asthma		
☐	Autoimmune condition (specify type)		
☐	Bronchitis		
☐	Cancer (specify type)		
☐	Chronic Fatigue Syndrome		

☐	Crohn's Disease or Ulcerative Colitis		
☐	Depression		
☐	Diabetes (Specify: Type I, II, Prediabetes, Gestational Diabetes)		
☐	Dry, itchy skin, rashes, dermatitis		
☐	Eczema		
☐	Emphysema		
☐	Epilepsy, convulsions, or seizures		
☐	Eye Disease (please specify)		
☐	Fibromyalgia		
☐	Food Allergies or Sensitivities		
☐	Fungal Infection (athlete's food, ringworm, other)		
☐	Gallbladder Disease/Gallstones (specify)		
☐	Gout		
☐	Heart attack/Angina		
☐	Heartburn		
☐	Heart disease (specify)		
☐	Hepatitis		
☐	High blood fats (cholesterol, triglycerides)		
☐	High blood pressure (hypertension)		
☐	Hypoglycemia (low blood sugar)		
☐	Intestinal Disease (specify)		
☐	Inflammatory Bowel Disease (Crohn's or Ulcerative Colitis)		
☐	Irritable bowel syndrome		
☐	Kidney disease/failure or Kidney stones		
☐	Lung disease (specify)		
☐	Liver disease		
☐	Mononucleosis		
☐	Osteoporosis		
☐	PMS		
☐	Polycystic Ovarian Syndrome		
☐	Pneumonia		
☐	Prostate Problems		
☐	Psychiatric Conditions		
☐	Seizures or epilepsy		
☐	Sinusitis		
☐	Sleep apnea		
☐	Stroke		
☐	Thyroid disease (hypo- or hyperthyroid)		
☐	Urinary Tract Infection		
☐	Other (describe)		
	Injuries		
☐	Back injury		
☐	Broken (specify)		
☐	Head injury		
☐	Neck injury		
☐	Other (describe)		

	Diagnostic Studies		
☐	Barium Enema		
☐	Bone Scan		
☐	CAT Scan: Abdomen, Brain, Spine (specify)		
☐	Chest X-ray		
☐	Colonoscopy or Sigmoidoscopy (specify)		
☐	EKG		
☐	Liver scan		
☐	NMR/MRI		
☐	Upper GI Series		
☐	Other (describe)		
☐	Operations		
☐	Dental Surgery		
☐	Gall Bladder		
☐	Hernia		
☐	Hysterectomy		
☐	Tonsillectomy		

5. Do you have complaints about any of the following?

_____Appetite
_____Bleeding gums
_____Bruising
_____Chewing or swallowing
_____Constipation
_____Diarrhea
_____Edema
_____Indigestion
_____Menstrual difficulties
_____Seeing in dim light
_____Sudden weight change
_____Stress

6. Do you use tobacco in any way? ☐ Yes ☐ no How much? _____
Did you recently stop smoking? ☐ Yes ☐ no

7. Are you currently seeing any healthcare providers that you would like to include in your nutrition care and plans? _____

Section 4: Nutrition History

1. What change in your health or nutrition habits would you like to make? What nutrition concerns do you have? _____

_____

_____

2. Do you follow a special dietary plan *prescribed for you, recommended by a medical provider or for religious reasons*? Examples include: low cholesterol, kosher or vegetarian? _____

3. Have you ever *chosen* to follow a special diet, eating pattern, training meal plan? Examples include: Paleo, Weight Watchers, Atkins, marathon training eating plan or off-season eating plan. ☐ Yes ☐ no

Name/Description of Diet or Plan	Dates Followed (List multiple dates if more than once)	Outcomes

4. Please list all vitamins, minerals, herbals, supplements, ergogenic aids, performance enhancers, protein powders, meal replacements or other nutraceuticals you are currently taking or have taken/used in the past year.

Name/Description	Dosage/Quantity	Frequency	Start Date	Stop Date
Example: One A Day Men's Multi Vitamin	*1200mg*	*Daily*	*1/5/2015*	*Current*

5. Do you tend to eat at regular or set times each day? ☐ Yes ☐ No What are they or explain? _____

_____

6. Are there certain foods that you do not eat ***ever***? _____
Why?_____

7. What beverages do you typically drink within a week and how much? _____

_____

8. How much water do you drink daily? _____

9. Do you drink energy drinks? ☐ Yes ☐ No What and how often? _____

10. Where do you eat on a regular basis? Check all that apply.

☐ Home/House/Apartment
☐ Desk
☐ Room (Specify_____)
☐ Work Provided Eating Area
☐ Car
☐ Restaurants
☐ Food Carts
☐ Other: _____

Nutrition Recall *Please write out a list of your typical food and beverage intake.*

Time	Food/Meal Description	Amount Eaten

11. Eating Style: Based on how you eat on a regular basis, please check all that apply.

☐ Fast eater
☐ Family members have different tastes
☐ Erratic eater
☐ Love to eat
☐ Emotional eater (stressed, bored, sad, etc.)
☐ Eat too much
☐ Eat because I have to
☐ After dinner nibbler
☐ Late night-eater
☐ Dislike "healthy" food

☐ Travel frequently
☐ Do not plan meals/menus
☐ Rely on convenience items
☐ Love to cook
☐ Hate to cook
☐ Confused about food/nutrition
☐ Poor snack choices
☐ Negative relationship with food
☐ Struggle with eating issues
☐ Eat to look good
☐ Eat to be healthy
☐ Eat for athletic performance
☐ Grazer or snack through the day
☐ Three square meals in the day
☐ Feed the family and then myself
☐ Eat healthy but don't like my body

Section 5: Weight History (Please do not complete this section if this is not relevant to your visit.)

1. Would you like to be weighed and/or measured today for a body composition assessment? ☐ Yes ☐ No
2. Height _____ Current Weight _____ Desired Body Weight _____
3. Highest Adult Weight _____ When? _____ Weight 1 year ago _____
4. Have you had any recent changes in your weight, percent body fat or lean muscle mass you're concerned about? ☐ Yes ☐ No
If yes, please explain:_____

5. Have you tried to lose weight before? _____ How were you successful and how were you not successful?

_____

_____

_____

6. What type of assistance are you hoping to receive today and in the upcoming months regarding your weight? _____

_____

7. Have you made any food changes recently in your life you feel good about? ☐ Yes ☐ No What are they? _____

_____

8. Please add any additional information you feel may be relevant to understanding your weight health. _____

_____

_____

Section 6: Digestive Health History

1. Do you associate any digestive symptoms with eating certain foods? ☐ Yes ☐ No
Please explain: _____
2. How often do you have a bowel movement? _____
3. If you take laxatives, what type/brand and how often? _____
4. Would you describe your stools as normal, hard, soft, or loose? _____
5. Please indicate how often you experience the following symptoms: (circle one for each)

Heartburn	Often	Sometimes	Rarely
Gas	Often	Sometimes	Rarely
Bloating	Often	Sometimes	Rarely
Stomach Pain	Often	Sometimes	Rarely
Nausea/Vomiting	Often	Sometimes	Rarely
Diarrhea	Often	Sometimes	Rarely
Constipation	Often	Sometimes	Rarely

Section 7: Activity and Exercise History

1. Do you enjoy physical activity? ☐ Yes ☐ No Explain: _____

2. Which of the following describes the amount of moderate or vigorous activity you have maintained in the past 2-6 months. This only includes purposeful movement you do in addition to your normal daily routine, most days:

- ☐ Less than 30 minutes
- ☐ 30-60 minutes
- ☐ More than 60 minutes
- ☐ More than 120 minutes
- ☐ More than 180 minutes
- ☐ Participate in elite or professional sports/training

3. Please indicate all types of activity and duration you regularly participate in:

Activity	Type/Intensity (low-moderate-high)	Days per Week	Duration (Minutes)
Stretching/Yoga			
Cardio/Aerobics (Walk, jog, bike, swim, elliptical) List:			
Strength-training (Weight lifting, pilates, advanced yoga) List:			
Recreational Sports (Basketball, soccer, slow pitch)			
Elite Sports or Training (Marathon, triathlon, sports)			
Leisure (Lawn games, gardening, etc)			
Other (specify/describe)			

4. Do you have any barriers to some or all types of activity? _____

_____

5. Do you currently have anyone assisting you or training you in your exercise? _____ Are you interested in a fitness assessment or customized training program? (*This is a complimentary offer to assist you in your nutrition-related goals.) _____

Section 8: Performance and Elite Exercise (Please do not complete if not relevant to your lifestyle or visit.)

1. Explain the elite training or sports you participate in.

Type/Description	Details	Frequency/Duration per week	Months/Years of Participation	PR/Goals/Upcoming Events

2. Please write out your typical training and event schedule. (weekly, monthly or applicable time frame)

3. Do you eat or drink any pre-workout, pre-competition, post-workout or post-competition foods, meals, bars, supplements or beverages? _____ Please list and/or explain _____

4. Have you ever received or currently receive sports nutrition advice? _____ What and are you still implementing? _____

_____

5. What nutrition-related questions or concerns do you have regarding your performance or training? _____

_____

Section 9: Socioeconomic History

1. Circle the last year of school attended:

1 2 3 4 5 6 7 8	9 10 11 12	1 2 3 4	M.A.	Ph.D.
Grade School	High School	College		

Other type of school_____

2. Are you employed? _____ Occupation_____

☐ working inside the home or telecommuting ☐ Part Time
☐ working inside the home raising a family ☐ Full Time
☐ working outside the home ☐ Student

3. Present marital status (circle one):
Single Married Divorced Widowed Separated Engaged

4. Please write the names and ages of any children, if any. _____

Section 10: Lifestyle

1. Do you have a refrigerator? _____ Stove? _____ Microwave? _____

2. Who typically buys food, groceries and/or meals for your household? _____

3. How many meals per week do you eat that are home-cooked or prepared? Breakfast _____ Lunch _____ Dinner _____

4. Who prepares most of the meals in your home? _____

5. Do you have any problems purchasing foods that you want to buy? _____

6. Do you use convenience or "fast foods" daily? ☐Yes ☐ No Describe _____

7. How often do you eat out? _____
Where? _____

8. Drug use? ☐ Never ☐ In the past ☐ Currently ☐ Prefer not to discuss Type/frequency_____

9. How do you spend the majority of your days? Job, occupation, volunteering, etc. Please describe and list number of hours/week.

_____

_____

10. How much time do you spend in a car or public transportation most days? _____
11. Does anyone outside your immediate family live in your household? _____ Whom? _____
12. How many hours of sleep do you get each night? Weekdays _____ Weekends_____

Section 11: Stress

1. Please rate your overall stress level. No Stress 1 2 3 4 5 A lot of Stress

2. Indicate *daily* stressors and rate the level of stress from 1 (extremely low) to 10 (extremely high):
Work_____ Family_____ Social_____ Financial_____ Health_____ Other_____

3. How do you know if and when you are stressed? (i.e.: tense neck) _____
_____

4. What helps you to unwind? _____

5. Are you able to do the above de-stressors daily, weekly or more occasionally? _____

Section 12: Goals and Desired Outcomes

1. What information would you like from the dietitian? _____
_____

2. What would you like to accomplish related to your nutrition health? _____
_____

3. Have you made any food changes recently in your life you feel good about? ☐ Yes ☐ No What are they? _____
_____

4. The nutrition/eating habits that are most challenging for me are: _____
_____

5. The nutrition/eating habits that I am most pleased with are: _____
_____

6. If I could change three things about my health and nutritional habits, they would be:
   1. _____
   2. _____
   3. _____

7. 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 willing/ready 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					
Meet regularly with a dietitian					

8. Please add any additional information you feel may be relevant to understanding your nutritional health. _____

_____

_____

9. Who could support and encourage you to make these changes? _____

Thank you for your willingness to share this information. I look forward to working with you to make lifestyle changes to meet your food and fitness objectives.

Food Frequency Questionnaire

Beverage Type	Daily Amount	Weekly Amount	Monthly Amount
Example: Coffee: ☑ reg. ☐ decaf. ☐ Latte ☐other	Two, 8oz cups	———	———
Water: ☐ tap ☐ filtered ☐ bottled			
Coffee: ☐ reg. ☐ decaf. ☐ Latte ☐ other			Text
Tea: ☐brewed ☐iced ☐sweet ☐commercial brand			
Juice: ☐ natural ☐ fruit drink ☐ smoothie ☐juicer			
Cokes: ☐ regular ☐ diet			
Milk: ☐ whole ☐ 2% ☐ 1% ☐ skim			
Milk alternative:			
Alcohol ☐ wine ☐ beer ☐ liquor			
Sports Beverage:			
Store Bought Drinks: Lemonade, V8, etc			
Other:			

How Often Do You Eat?	Never	2-3x/ month	1x/week	2-3x/ week	1x/day	2-3x/ day
Fast Food						
Restaurant Food						
Vending Machine Food						
Cafeteria or Buffet Food						
Frozen Meals						
Home-Cooked Meals						
Leftovers						
Frozen Foods						
Artificial Sweeteners, type:						
Meal Replacements (bar, shake, etc) type:						
Protein powder						
Yogurt, type-						
Cheese (natural, processed)						
Cottage cheese						
Milk desserts (pudding, custard, ice cream)						
Beef (hamburger, steak, etc)						
Pork (chop, loin, ham, bacon, etc)						
Poultry (chicken, turkey, etc)						
Fish (fresh, frozen, canned), type:						
Deli Meat, Type:						
Eggs						
Dried beans, legumes						
Peanut butter or almond butter						
Nuts, seeds						
Soyfoods (tofu, tempeh, TSP, flour)						
Bread						

How Often Do You Eat?	Never	2-3x/ month	1x/week	2-3x/ week	1x/day	2-3x/ day
Cereals						
Pasta, noodles						
Rice, quinoa, bulgur, oatmeal, etc						
Cornbread, muffin, bagel, biscuit, pancake, pizza						
Crackers						
Popcorn						
Cookies, cake, pie						
Donuts, pop tarts						
Chips, Cheetos, pretzels						
Other packaged/processed foods						
Orange/red/yellow vegetables (carrots)						
Green vegetables (broccoli)						
Leafy vegetables (Spinach, kale, collard greens)						
Starchy vegetables (potato, rutabaga, squash)						
Other vegetables						
Orange/red/yellow fruits (orange)						
Berries (strawberries)						
Stone fruits (peach)						
Other fruits						
Butter, margarine						
Cooking oil						
Sour cream, mayonnaise, salad dressing						
Candy						

Inflammation and Nutrition Related Symptoms Questionnaire

Rate each of the following symptoms based upon your typical health profile for the past 30 days. If you have been having recent or somewhat severe health symptoms, please indicate that you will fill out the questionnaire for the past 48 hours.

Point Scale:
0 = Never or almost never have the symptom
1 = Occasionally have it; effect is not severe
2 = Occasionally have it; effect is severe
3 = Frequently have it; effect is not severe
4 = Frequently have it; effect is severe

HEAD
____Headaches*
____Lightheadedness**
____Dizziness
____Insomnia
____Faintness**
_____TOTAL

EARS
____Itchy ears
____Ringing in ears/loss of hearing
____Earaches/ear infections
____Drainage from ear
_____TOTAL

EYES
____Bags or dark circles under eyes*
____Watery or itchy eyes
____Swollen, reddened, or sticky eyelids
____Blurred or tunnel vision (excluding near- or far-sightedness)*
_____TOTAL

NOSE
____Stuffy nose
____Sinus congestion, sinus infection
____Constant sneezing
____Hay fever/allergies
____Excess mucus formation*
_____TOTAL

MOUTH/THROAT
____Chronic coughing
____Sore throat, hoarseness, loss of voice
____Gagging, frequent need to clear throat
____Swollen tongue, gums or lips**
____Swollen lymph nodes
____Canker sores, mouth ulcers**
_____TOTAL

HEART
____Chest pain
____Irregular or skipped heartbeat**
____Rapid or pounding heartbeat*
_____TOTAL

LUNGS
____Asthma, bronchitis
____Chest congestion
____Shortness of breath
____Difficulty breathing**
_____TOTAL

SKIN
____Acne
____Brown “age/liver spots”*
____Hives, rashes, cysts, boils*
____Dry skin
____Eczema or psoriasis*
____Itchy skin/dermatitis*
____Flushing, hot flashes
____Discoloration*
____Skin tags*
____Body odor
____Excessive sweating
____Pallor**
_____TOTAL

HAIR/NAILS
____Hair loss*

____Brittle hair
____Thinning Hair*
____Brittle nails*
____White crescents on nails*
____Cracking nails*
____Ridges or bumps on nails**
____Thin nails**

JOINTS/MUSCLES
____Pain or aches in joints or lower back
____Tingling or numbness**
____Stiffness or limitation of movement*
____Arthritis*
____Pain or aches in muscles
____Weakness**
_____TOTAL

MENTAL/EMOTIONAL
____Poor memory*
____Difficulty concentrating**
____Mood swings*
____Depression**
____Anxiety, fear or nervousness
____Anger, irritability, or aggressiveness
____Insomnia**
_____TOTAL

ENERGY LEVEL
____Fatigue/low energy**
____Sleepiness**
____Restlessness*
____Hyperactivity*
____Feeling of weakness*
_____TOTAL

WEIGHT
____Underweight*
____Overweight*
____Difficulty losing weight*
____Water retention*
____Crave certain foods**
_____TOTAL

DIGESTIVE TRACT
____Nausea, vomiting*
____Diarrhea*
____Constipation**
____Bloated feeling*
____Belching, passing gas*
____Heartburn*
____Intestinal/stomach pain*
_____TOTAL

OTHER
____PMS*
____Frequent colds, flus*
____Chemical or environmental sensitivities
____Food allergies/sensitivities*
____Frequent or urgent urination
____Genital itch or discharge
_____TOTAL

GRAND TOTAL _____

15 or lower: low level of inflammation and nutrition influenced symptoms
16 to 49: moderate level of inflammation and nutrition influenced symptoms
50 or higher: high level of inflammation and nutrition influenced symptoms

*Indicates symptoms related to nutrition or nutrition-related conditions
** Indicates symptoms related to nutritional deficiency