Nutrition Consultation QUESTIONNAIRE

DOWNTOWN FAMILY YMCA

Name: ____ Date: ________________________________

Age: _______ Phone: __________________________ Email: _________________________________

Occupation: ____

Work/School Hours: ____

Please list other people in your household and their relationships to you: ________________________________

____

GENERAL HEALTH INFORMATION

Physician's name: ____

Physician's Phone: ____

Physician's address: ____

Date of most recent exam: ________________________ Date of recent blood tests: ______________________

How do you rate your health? (Please circle) Poor Fair Good Excellent

Height: _____________ Weight: ______________

How often do you use tobacco? __________________________ Alcohol? ______________________________

How many hours of sleep do you average per night? ____________ Is your sleep restful? Yes No

On a scale from 1 (low) to 5 (high), how would you rate your daily stress level? 1 2 3 4 5

How do you cope with stress in your daily life? ____

____

Please list any religious practices that affect your health care or diet: ___________________________________

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List all prescription and over-the-counter medications that you currently take (include the dosages):

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List all vitamins, minerals, supplements, and herbs that you take:

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On a scale of 1 (not ready) to 5 (ready), how ready are you to make lifestyle changes? 1 2 3 4 5

On a scale of 1 (not confident) to 5 (confident), how confident are you to make lifestyle changes? 1 2 3 4 5

What makes it hard for you to lose weight and keep it off? ________________________________

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REVIEW OF SYSTEMS (*CIRCLE ALL THAT YOU CURRENTLY HAVE OR ARE CONCERNED ABOUT*)

RESPIRATORY
Shortness of breath
Coughing
Asthma or Wheezing
Emphysema
Snoring
Daytime Sleepiness
Disturbed Sleep
Sleep Apnea
History of Pneumonia
Chronic Bronchitis
COPD

GASTROINTESTINAL
Nausea/Vomiting
Abdominal/Stomach pain
Heartburn/Acid Reflex
Ulcer Disease
Belching/Burping
Rectal Bleeding
Hemorrhoids
Constipation/Diarrhea
Gallbladder Disease/Gallstones
Celiac Disease/Gluten Intolerance
Hernia

CARDIOVASCULAR
High blood Pressure
Heart disease/Heart attack
Congestive Heart Failure
Heart Murmur
Irregular Heartbeat or Palpitations
Chest pain or Discomfort
Ankle or Feet Swelling
Varicose Veins
Blood Clots or Clotting Disorders

GENITOURINARY
Difficulty Urinating
Urinary Incontinence
Inability to Empty Bladder Fully
Recurrent Urinary Tract Infection
Infertility
Abnormal Menstrual Periods
Enlarged Prostate

MUSCULOSKELETAL
Aching Muscles/Joints
Lower Back Pain/Disc Problems
Arthritis

SKIN & HAIR
Skin Sores/Infections
Bruises Easily
Chronic Rashes/Dermatitis/Eczema

ENDOCRINE
Diabetes Mellitus
High Cholesterol
High Triglycerides
Thyroid Disease
Gout

OTHER
Low Energy Level
Bipolar Disorder
Attention Deficit Disorder (ADD)
Hyperactivity Disorder (ADHD)
Depression
Anxiety Disorder or Panic Attacks
Binge Eating
Obsessive-Compulsive Disorder (OCD)
Anorexia
Anemia
Bulimia
Headaches or Migraines

Other serious medical conditions (list types): -

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____

Do you have a family history of any of the following? (Circle all that apply)

High Blood Pressure High Cholesterol Diabetes Obesity
Heart Disease Cancer Thyroid Disease

Other (list): ____

____

List the types of surgeries you have had: ____

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NUTRITIONAL INFORMATION

What one or two things would you like to change about your diet? ________________________________

____

PHYSICAL ACTIVITY INFORMATION

What is the most physically active thing you do in an average day? ________________________________

____

What, if any, regular exercises do you do? How often and for how long do you participate? _____________

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Do you know of any reason (s) why you should not do physical activity? Yes No

If yes, please explain the reasons: ____

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Please provide any additional information that may be helpful or necessary:

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Client's Signature ____

Please describe in detail ***when, what and the amount you usually eat*** in a typical day. (Write "None" if you do not eat that meal or snack)

FOOD Diary	TIME	FOODS YOU TYPICALLY EAT	AMOUNT
BREAKFAST			
SNACK			
LUNCH			
SNACK			
DINNER			
SNACK			