



Nutrition Consultation QUESTIONNAIRE

YMCA AT NORTON COMMONS

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: _____

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

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

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? _____

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): -

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

High Blood Pressure
Heart Disease

High Cholesterol
Cancer

Diabetes
Thyroid Disease

Obesity

Other (list): _____

List the types of surgeries you have had: _____

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? _____

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

If yes, please explain the reasons: _____

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

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			