BRING THIS COMPLETED FORM TO YOUR APPT AT SPECTRA HEALTHCARE

Nutrition / Weight History

Chief Nutritional Concern____

Ht _____Wt ______Usual weight(past 3 months)___________Last date at usual weight?________
Greatest Adult Weight? (past 10 yrs)_________Lowest Adult weight (past 10yrs)______________
"Your Expected Weight Goal"?____
Recently, Have you? ☐ gained weight ☐ lost weight ☐ remained the same

1. Are you following a special diet? ☐ Yes ☐ No
   If so, Please describe?____
2. How many meals do you eat a day? ☐ 1 ☐ 2 ☐ 3 ☐ Other ______________________________
3. Who cooks the meals at home?____
4. How many snacks a day? ☐ 1 ☐ 2 ☐ 3 ☐ None
5. At what time(s) do you snack?____
   What foods?____
6. How often do you eat out? ☐ Daily____x day ☐ Weekly____x week ☐ Monthly______x month
7. What restaurants do you frequent? ____
8. Do you take Vitamins/Minerals/Herbs/Supplements? ☐ Yes ☐ No
   If yes, Please list____
9. Do you smoke? ☐ Yes ☐ No ☐ Quit (date)____
10. Do you drink Alcoholic Beverages? ☐ Yes ☐ No
    Type and How often?____
11. Do you exercise? ☐ Yes ☐ No
    How often?____
12. Any Food allergies or Food Intolerance's?____
    ____
13. Any Digestive Disorders? ____
    ☐ Constipation ☐ Diarrhea ☐ Gas ☐ Bloating

Please **mark (✓)** those which apply to you & indicate # of oz per day:

- ❑ Fruit juice_________
- ❑ Milk______________
- ❑ Reg Soda_______
- ❑ Diet soda__________
- ❑ Water_____________
- ❑ Coffee_________

Thoughts/ feelings while eating? Please **mark (✓)** those which apply to you:

- ❑ Anxiety
- ❑ Loss of control
- ❑ Hunger
- ❑ Calmness
- ❑ Guilt
- ❑ Stress
- ❑ Happiness
- ❑ Boredom
- ❑ Anger

Activities usually while eating? Please **mark (✓)** those which apply to you:

- ❑ Television
- ❑ Family
- ❑ "On the run"
- ❑ Reading
- ❑ Alone
- ❑ Computer
- ❑ Other____________

14. How often do you weigh? ________________Why?______________________________
    ____
15. Do you feel you weight cycle (repeatedly lose and regain) and how many times in the past ? ____
16. How many times have you been on a diet? ____
17. When/What was your last diet? ____

Amount of weight loss:____
How long did you maintain the weight loss_______________________________________
How much weight was regained after the diet?____________________________________
In what time period? ____
Why do you think the weight was regained?______________________________________

18. Please **mark (✓)** those which apply to you:
    - ☐ Overweight since childhood
    - ☐ Overweight in middle school
    - ☐ Overweight in high school
    - ☐ Overweight after pregnancy
    - ☐ Other__________________

19. How many and who in your family, (parents, siblings, children) are about your size, height, and body shape or type?

    ____

    ____
20. How often do you eat when you are not hungry and why?

    ____
21. How often do you restrict eating even when you are hungry and why?

    ____
22. How often do you fast? Never Sometimes Usually Always
    For how long?__________________ Reason:______________________________________

    ____
23. Do you have cravings for any foods? ____
    What foods and when?____

    ____
24. Do you crave sweets?__________________ How often?_____________________________
25. What foods do you avoid and why?

    ____
26. List favorite foods

    ____
27. Do you feel you eat (circle one)
    As much as you should More than you should Less than you should

28. Is your appetite (circle one):

    Excellent Good Fair Poor

29. Is your diet (circle one):

    Excellent Good Fair Poor

30. Describe your current diet. Is it a special diet prescribed by a doctor or other health professional? ____
31. What would you like to accomplish or gain from nutritional counseling?_____________

    ____