Office Use: HT _____
WT _____
BMI _____
IBW _____

# Nutrition Profile

Name: _____ Date: _____

Age: _____ Ht: _____ Weight: _____ Usual Weight: _____

Do you have: Diabetes ☐ High Blood Pressure: ☐ High Cholesterol: ☐

1. Do you know why you are here to see the dietitian? ☐ yes ☐ no
   If yes, why? _____
   _____

2. Has anyone advised you to make diet changes? ☐ yes ☐ no. If yes, who? _____

3. Do you know the health benefits if you modify your eating habits? ☐ yes ☐ no

4. How would you rate your motivation to change your eating habits? (circle one)
   1) Not motivated 2) Somewhat motivated 3) Motivated 4) Highly motivated

5. Are you ready to make changes now? ☐ yes ☐ no

6. What do you want to happen with the dietitian/ what would you like to go away with?
_____
_____

7. Do you have any cultural or religious practices that may influence what you eat? ☐ yes ☐ no

8. Do you exercise? ☐ yes ☐ no
   If yes, what kind and how often? _____

9. Do you have any food allergies? ☐ yes ☐ no

10. Do you take any medications? ☐ yes ☐ no If yes, please list any medications that you take for diabetes, high blood pressure, cholesterol, weight management and any vitamins/minerals or herbal supplements:
_____
_____

11. Do you consume any of the following:

| | | | |
|---|---|---|---|
| Milk/yogurt/cheese | ☐ yes ☐ no | If yes, how many times DAILY ____ | How many times WEEKLY _____ |
| Fruit | ☐ yes ☐ no | If yes, how many times DAILY ____ | How many times WEEKLY _____ |
| Juices | ☐ yes ☐ no | If yes, how many times DAILY ____ | How many times WEEKLY _____ |
| Vegetables | ☐ yes ☐ no | If yes, how many times DAILY ____ | How many times WEEKLY _____ |
| Soda pop | ☐ yes ☐ no | If yes, how many times DAILY ____ | How many times WEEKLY _____ |

| | | | |
|---|---|---|---|
| Water | ☐ yes ☐ no | If yes, how many times<br>DAILY ____ | How many times<br>WEEKLY _____ |
| Sweets | ☐ yes ☐ no | If yes, how many times<br>DAILY ____ | How many times<br>WEEKLY _____ |
| Salty foods | ☐ yes ☐ no | If yes, how many times<br>DAILY ____ | How many times<br>WEEKLY _____ |
| Do you ever skip breakfast? | ☐ yes ☐ no | | How many times<br>WEEKLY _____ |
| Do you ever skip lunch? | ☐ yes ☐ no | | How many times<br>WEEKLY _____ |
| Do you ever skip dinner? | ☐ yes ☐ no | | How many times<br>WEEKLY _____ |

12. Describe a <u>typical</u> day's eating pattern. Please note what you usually eat.

| Breakfast | Lunch | Dinner |
|---|---|---|
| A.M. Snacks | Afternoon Snacks | Evening Snack |

Please download and complete this form and bring it with you to your first appointment.