

Date _____

Name (Last, First)		Preferred Name	
Phone Number		Race (please check all that apply)	
Age		Year in School	
Gender	<input type="checkbox"/> Female <input type="checkbox"/> Male	<input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian	<input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Unreported/ Refused to Report <input type="checkbox"/> White
Who referred you to our services?		<input type="checkbox"/> Advisor/Professor/TA <input type="checkbox"/> Campus Rec <input type="checkbox"/> CAPS <input type="checkbox"/> Coach/Athletic Staff	
Have you seen a dietitian before?		<input type="checkbox"/> Family Member <input type="checkbox"/> Friend <input type="checkbox"/> Health Center Staff <input type="checkbox"/> Other _____	
Why do you want to see a dietitian? (please check all that apply)		<input type="checkbox"/> Residence Hall Staff <input type="checkbox"/> Self	
		<input type="checkbox"/> Yes If yes, who and when? _____ <input type="checkbox"/> No _____	
		<input type="checkbox"/> Anemia <input type="checkbox"/> Diabetes <input type="checkbox"/> Disordered eating concerns <input type="checkbox"/> Food Intolerance <input type="checkbox"/> General healthy eating advice	
		<input type="checkbox"/> High blood pressure <input type="checkbox"/> High cholesterol <input type="checkbox"/> Irritable Bowel Syndrome <input type="checkbox"/> Other _____	
		<input type="checkbox"/> Vegetarian eating <input type="checkbox"/> Want to gain weight <input type="checkbox"/> Want to lose weight	

MEDICAL HISTORY		
Are you currently being treated for a medical condition?	<input type="checkbox"/> Yes <input type="checkbox"/> Not Sure <input type="checkbox"/> No	If yes, explain _____
Are you taking any medications or over-the-counter drugs?	<input type="checkbox"/> Yes <input type="checkbox"/> Not Sure <input type="checkbox"/> No	If yes, list: _____
Are you taking any supplements or herbs?	<input type="checkbox"/> Yes <input type="checkbox"/> Not Sure <input type="checkbox"/> No	If yes, list: _____
Do you have a family history of diabetes?	<input type="checkbox"/> Yes <input type="checkbox"/> Not Sure <input type="checkbox"/> No	If yes, explain _____
Do you have a family history of high cholesterol?	<input type="checkbox"/> Yes <input type="checkbox"/> Not Sure <input type="checkbox"/> No	If yes, explain _____
Do you have any food allergies or intolerances?	<input type="checkbox"/> Yes <input type="checkbox"/> Not Sure <input type="checkbox"/> No	If yes, explain _____

QUESTIONS		
Height _____ feet _____ inches	Present weight, if you know _____ Usual weight _____ Desired weight range _____	Weight when you graduated from high school _____
Have you had any recent weight change?	<input type="checkbox"/> Gain <input type="checkbox"/> Loss	How much and how fast: _____
Have you ever had concerns about your weight?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Overweight <input type="checkbox"/> Underweight Comments: _____ _____ _____

EATING BEHAVIORS			
Does your food intake or your weight feel out of control?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Has your appetite changed within the last month?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, explain _____ _____	
How many meals do you eat per week at:	_____ Home _____ Dining Hall _____ Other (Please explain) _____	_____ Fast-Food Chain _____ Greek house	_____ Restaurant
How would you generally describe your eating habits?	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	How often do you eat fewer than 3 times a day?	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Rarely <input type="checkbox"/> Never <input type="checkbox"/> Almost daily
If you skip meals, which meals do you most often skip?	_____		
How many snacks do you eat most days?	_____	Typical snacks: _____	
Are you on a special diet?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Who prescribed or suggested this diet for you?	<input type="checkbox"/> Family <input type="checkbox"/> Physician <input type="checkbox"/> Friend <input type="checkbox"/> Self-elected
Please specify type of diet:	<input type="checkbox"/> Diabetic <input type="checkbox"/> Other (describe) _____	<input type="checkbox"/> Gluten free	<input type="checkbox"/> Low carb <input type="checkbox"/> Vegetarian

BEVERAGES			
Please check the beverages you consume on a typical day. When applicable, add the approximate amount consumed	<input type="checkbox"/> Reg. soda _____ <input type="checkbox"/> Diet soda _____ <input type="checkbox"/> 100% fruit juice _____ <input type="checkbox"/> Fruit drink/punch _____ <input type="checkbox"/> Other (please explain) _____	<input type="checkbox"/> Reg. coffee _____ <input type="checkbox"/> Decaf. coffee _____ <input type="checkbox"/> Plain water _____ <input type="checkbox"/> Flavored water _____	<input type="checkbox"/> Tea _____ <input type="checkbox"/> Protein drink _____ <input type="checkbox"/> Energy drink _____

ALCOHOL			
How often do you drink alcohol?	<input type="checkbox"/> 0-1 time/month <input type="checkbox"/> 2-3 times/month	<input type="checkbox"/> 1-2 times/week <input type="checkbox"/> 3-4 times/week	<input type="checkbox"/> 5+ times/week
How many drinks do you consume when you drink?	<input type="checkbox"/> Do not drink <input type="checkbox"/> 1-2 drinks <input type="checkbox"/> 3-5 drinks <input type="checkbox"/> 6-8 drinks <input type="checkbox"/> 9 or more drinks (1 drink = 1.5 oz. liquor, 5 oz. wine, or 12 oz. beer)		

TOBACCO	
Do you smoke?	<input type="checkbox"/> Yes If yes, how much? _____ <input type="checkbox"/> No

PHYSICAL ACTIVITY	
Do you currently exercise?	<input type="checkbox"/> Yes How frequently do you exercise aerobically? _____ days/week <input type="checkbox"/> No How long? _____ min/day
What do you do for aerobic activity?	_____
How frequently do you strength train?	_____ days/week How long? _____ min/day
Do you have any exercise limitations?	<input type="checkbox"/> Yes If yes, describe _____ <input type="checkbox"/> No
What do you do for leisure activities?	_____
Hours spent:	Sleeping per night _____ Working per week _____ Type of work: _____

Please add any other information you feel may be important for the dietitian to know
