



GENERAL ASSESSMENT

Directions:

Please fill out the entire questionnaire with as much detail as possible. If you have any questions regarding the questionnaire please contact Dina@DMANutrition.com

NAME: _____ AGE _____ SEX : M F

BEST NUMBER TO REACH YOU AT: _____

HEIGHT:

REASON FOR NUTRITIONAL COUNSELING: (PLEASE CIRCLE)

Diabetes Type 1 Type 2 Weight Loss

High Cholesterol or High Triglycerides General Nutrition Information

Other:

MEDICAL HEALTH CONDITIONS

Please check the yes or no of any conditions that a doctor has diagnosed or you have been treated for.

Health Conditions:	Yes	No
Hypertension (High Blood Pressure)		
Coronary heart disease		
Hyperlipidemia		
Stroke (s)		
Impaired fasting glucose (Pre Diabetes)		
Type 2 Diabetes		
Sleep Apnea		
Pulmonary or Respiratory Disorders		
Gallstones or Gallbladder Disease		
Arthritis		
Renal or Kidney Disease		
Musculoskeletal disease:		
Osteoarthritis		
Gout		
Cancer		
If yes, please describe what kind:		
Reproductive function		
Menstrual irregularity		
Infertility		
Poly-cystic ovarian syndrome		
Gestational diabetes		
Other health conditions		
Hypothyroid		

Poor wound healing		
Other: (Please Specify)		

When was the last time you went to see your primary care physician or had a full physical including any blood drawn for labs?

MEDICATIONS (PLEASE CIRCLE ANSWERS AND FILL IN AS MUCH DEATAIL AS POSSIBLE)

Are you taking any medications? YES NO

Please list any and all Current Medications: (Please list the name, amount and frequency.)

Name of Medication	Amount	Frequency (times per day)

Are you taking any Vitamins or Supplements? YES NO

What vitamins or minerals are you currently taking? (Please list the name, amount and frequency.)

Name of Vitamin	Amount	Frequency (times per day)

FAMILY MEDICAL HISTORY

Can you please describe your parent's significant medical history?

(Heart disease, strokes, diabetes, high cholesterol, high blood pressure, etc)

Father:	Mother:

SOCIAL HISTORY (PLEASE DESCRIBE WITH AS MUCH DETAIL AS POSSIBLE)

Besides you who do you live with? (Name, relation and age)

NAME	RELATION	AGE

How often do you?: (Please circle)

Travel for business: Never Rarely Occasionally Always Often

Travel for Pleasure: Never Rarely Occasionally Always Often

Do you? (Please circle which one or ones best apply to you)

Work: Part Time Full Time

Student: Part Time Full Time

Other:

WEIGHT HISTORY (PLEASE ANSWER WITH AS MUCH DEATIL AS POSSIBLE)

What was your? (Please answer in pounds and years)

Lowest Adult weight (over 21) and Age at that weight:_____

Highest Adult (over 21) and Age at that weight:_____

Usual Weight (for the past 6 months-12 months):_____

What is your over all Goal Weight: _____

Diet History:

Please list any foods that you do not eat for religious, cultural beliefs or personal reasons.

Please put an X in the box that most resbles your nutrition and activity habits:

Nutrition and Activity Habits				
Food Choices	0-1 Times/Day	2-3 Times/Day	4-5 Times/Day	6-7 Times/Day
<i>How many times a day do:</i>				
Eat vegetables?				
Eat fruit?				
Eat whole grain breads and cereals?				
Eat fried foods?				
Drink sodas or sweetened fruit drinks?				
Drink milk or eat dairy foods?				
<i>What type of milk to you drink?</i>	Whole	2% 1%	Skim Soy	Don't drink it
Meal Patterns	0-1 Times/Week	2-3 Times/Week	4-5 Times/Week	6-7 Times/Week
<i>How many times do you:</i>				
Eat breakfast?				
Eat lunch?				
Eat dinner?				
Eat dinner with your family?				
Eat meals out or away from home?				
Physical Activity:	0-1 Times/week	2-3 Times/Week	4-5 Times/Week	6-7 Times/Week
<i>Do you do any Physical Activity? Yes No</i>				
How many times a week do you?				
<i>Participate in physical activity for a combined total of 30 minutes or more?</i>				
Describe what you do?				
How many hours a day do you?	Less than 1 hour/day	1-2 hours/day	3-4 hours/day	5 or more hours
Watch TV?				

Sit at a desk at work? Life Style Factors (Please Circle)				
How much alcohol do you consume?	Rarely	Occasionally	Socially	Often
Do you smoke?	Yes	No	PPD:	Years:
Do you ever feel that your eating is out of control?	Yes	No		
How often do you read food labels?	Never\Rarely	Sometimes	Often	Always

Please answer the following questions with as much detail as possible.

1. Do you eat after 8 pm? If so, what do you usually eat?

2. Can you recall ever eating to avoid doing something? If so, when what this?

3. Do you ever eat when you aren't hungry? If so, when?

4. Do you ever "treat" yourself with food? If so, when?

5. Where do you get most of your nutritional information?

6. When if any times of the day are you tired? After a meal, before a meal, etc?

7. What would you most like to get out of nutritional counseling? (Please be as detailed as possible. This is where I can figure out best to serve you.)

Thank you very much for taking the time and effort to fill this information out. Please print this off and bring it with you to our session. I really look forward to meeting with you and helping you achieve all of your nutritional goals.