SWEDISH

Swedish Nutrition Welcome Questionnaire

Name _____ Date of Birth _____

How did you hear about the Nutrition Clinic? _____

_____

What is the reason for your visit? _____

_____

_____

What are your goals for this visit? _____

_____

_____

Have you seen a dietitian before? No _____ Yes _____

Do you follow a special or specific diet? No _____ Yes _____

Have you done so in the past? No _____ Yes _____

If yes, what kind and when? _____

_____

Do you have food allergies or intolerances? No _____ Yes _____

List: _____

_____

Do you take vitamin, mineral or herbal supplements? No _____ Yes _____

If yes, please list what kinds and how much: _____

_____

_____

_____

Do you take any medications? No _____ Yes _____

If yes, please list what kinds and how much: _____

_____

_____

_____

(see reverse)

Weight History

What is your usual weight?_____ Have you had any recent weight changes? No _____ Yes_____

What is your curent weight?_____ Height? _____

What do you think is a healthy weight for you? _____

Your highest adult weight? _____ When? _____

Your lowest adult weight?_____ When? _____

Comments: _____

_____

Do you exericse regularly? No _____ Yes_____

If yes, what type of physical activity? _____

How often? _____

Do you have physical limitations? No _____ Yes_____

If yes, please explain:_____

Health Background

Please indicate whether you or your family members are affected by the following conditions. Leave addititional comments below as needed.

CONDITION	MYSELF	AGE AT ONSET	FAMILY	RELATIONSHIP/AGE AT ONSET
Anemia				
Cancer				
Celiac Disease				
Diabetes or Abnormal Blood Sugar				
Gestational Diabetes				
Heart Disease				
High Blood Pressure				
High Cholesterol				
Inflammatory Bowel Disease				
Kidney Disease				
Obesity (as an adult)				
Obesity (as a child)				
Stroke				
PCOS				
Sleep Apnea				
Depression				
Thyroid Issues				
Restless Leg Syndrome				
Gout				
Other (please list):				

Comments: _____

_____

_____

Any additional comments or considerations in planning your nutritional care? _____

_____

_____

_____