Nutrition Care Clinic
History Form

Name: _____ Date of Birth: _____ Today's Date: _____

Why are you coming to today's visit?

_____

_____

What are your nutrition goals?

_____

_____

Who referred you for this visit (doctor, therapist, etc.)? _____

Do you see specialty providers (allergist, gastroenterologist, etc.)? If so, please list what types:

_____

_____

MEDICATIONS AND NUTRITIONAL SUPPLEMENTS (including vitamins, minerals, herbs/botanicals, CBD, etc)

☐ I am not currently taking any medications
☐ See attached list
☐ See current list in my medical record
☐ My medications & supplements are listed below:

Medication & Supplements (name and dose)	Reason for use	Side effects, if applicable

WEIGHT HISTORY

Current weight: _____ lbs/kg Height: _____ in/cm

Do you currently weigh yourself? ☐ Yes ☐ No If **Yes**, how frequently? _____

Any recent weight changes? ☐ Yes ☐ No If **Yes**, please describe: _____

Have you followed, or are you currently following, any weight loss programs? ☐ Yes ☐ No
(For example: portion control, exercise, diet programs, pills, etc.) If **Yes**, please explain below:

Weight Loss Method	Brief Description

History of or current disordered eating? ☐ Yes ☐ No Comments _____

EXERCISE

How often do you exercise?
- ☐ Seldom/Never
- ☐ Weekly
- ☐ 2-3x / week
- ☐ 3-5x / week
- ☐ Daily

How long do you exercise?
- ☐ 10 – 15 minutes
- ☐ 15 – 30 minutes
- ☐ 30 – 60 minutes
- ☐ More than 60 minutes

How would you describe your exercise?
- ☐ Easy
- ☐ Moderate
- ☐ Intense

What type of exercise do you usually do?

_____

Is there any reason you cannot or should not exercise?

_____

ENERGY

Do you have as much energy as you would like? ☐ Yes ☐ No

Rate your energy on a scale of 0-10 with 10 = excellent 1 2 3 4 5 6 7 8 9 10

SLEEP

Do you wake up from sleep feeling refreshed? ☐ Yes ☐ No

How many hours do you sleep? _____hours

Do you use a breathing machine, such as a CPAP? ☐ Yes ☐ No

If **Yes**, do you use the machine regularly? ☐ Yes ☐ No

WOMENS' HEALTH

Do you have a regular menstrual cycle? ☐ Yes ☐ No

If **No**, briefly describe any issues (example: missed or heavy menstruation)

_____

Do you use hormonal birth control? ☐ Yes ☐ No

If **Yes**, list type_____

Are you in peri-menopause or pre-menopause? ☐ Yes ☐ No

Have you ever been diagnosed with Gestational Diabetes? ☐ Yes ☐ No

ALLERGIES & INTOLERANCES

Have you been tested for food allergies or sensitivities? ☐ Yes ☐ No

If **Yes**, please explain:

_____

_____

Please list any foods you avoid and why:

_____

_____

What allergies, sensitivities or intolerances to food have you experienced?

Allergies or intolerances	How soon after eating	Symptoms

SUBSTANCE USE

Tobacco use: ☐ Yes ☐ Not currently ☐ Never ☐ Passive smoke exposure

If **Yes**: Start date: _____ Quit date: _____ Packs per day? _____ How many years? _____

Smokeless tobacco: ☐ Currently ☐ Former user ☐ Never used If **Former user**, quit date? _____

Alcohol use: ☐ Yes ☐ Not currently ☐ Never

How many drinks per week: Glasses of wine _____ Cans/Bottles of beer _____ Shots of liquor _____

Recreational drug use: ☐ Yes ☐ Not currently ☐ Never If **Yes**, how many times per week? _____

What type/comments _____

DIET RECALL

Who does the shopping? _____ Who does the cooking? _____

How many times per week do you eat meals from outside the home? _____

Where do these meals come from? (check all that apply) ☐ Sit down restaurants ☐ Fast food ☐ Delivery

☐ Cafeteria at work ☐ Take out ☐ Food trucks ☐ Other _____

To the best of your ability, please write down your food and beverage intake from a typical day (include meals, snacks, beverages, portion sizes, and times).

Wake up time: _____am/pm Sleep time _____am/pm

Breakfast _____am/pm: _____

Snack _____am/pm: _____

Lunch _____am/pm: _____

Snack _____am/pm: _____

Dinner _____am/pm: _____

Snack _____am/pm: _____

Beverages & Glasses of Water: _____

Are you currently receiving food assistance (food stamps, food banks, WIC, etc.)?

☐ Yes

☐ No

☐ Need assistance

SWEDISH NUTRITION CARE CLINIC

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