INITIAL DIETITIAN CONSULT

Please fill out before your appointment

Name: ____ **Date of Birth:** _________________

Do you have any food allergies, food intolerances or special diet needs, if yes, please specify:
Vitamins, Minerals, Supplements that you currently take:

Previous Weight Loss Attempts (check or circle those that you have done)

□ Increased exercise □ Decreased calories/portions □ Very low calorie diets
□ Starvation □ Fad Diets □ Commercial Diets (Weight Watchers, Jenny Craig, NutriSystems) □ Hospital/Clinic Based Diet □ Liquid Diet (Slimfast, Optifast, Medifast) □ Ketogenic diet □ Eating Disorder (anorexia, bulimia/purging)
□ Worked with Registered Dietitian □ Prescription Medications: HCG, Phentermine, Fen-Phen, Xenical, Contrave, Belviq □ Physician supervised diet
□ Diabetes Education □ High protein/low carbohydrate □ Paleo
□ Whole 30 □ Other: _________________

Reasons Why Weight Loss Attempts Were Unsuccessful or Weight Was Re-gained

□ reached goal weight □ program/group ended □ moved from area □ cost
□ impatient □ lost job □ program hard to follow/maintain □ lack of commitment
□ mood worsened □ all or nothing thinking □ frustration/discouragement with poor results for effort □ slow rate of weight loss □ lack of support □ weight plateau
□ adverse reaction to medication □ self-sabotage □ unrealistic expectations
□ lack of accountability □ persistent hunger □ eating disorder
□ change/event in personal life □ not making healthy food choices
□ eating too large of portions □ emotional eating □ Other: _________________

Current Meal Pattern and Intake (What do you eat on a typical day?)

Breakfast **Time of Day:** **Food Eaten:**
Snack: **Time of Day:** **Food Eaten:**
Lunch: **Time of Day:** **Food Eaten**
Snack: **Time of Day:** **Food Eaten:**
Dinner: **Time of Day:** **Food Eaten:**
Snack: **Time of Day:** **Food Eaten:**
Middle of the Night: **Time of Night:** **Food Eaten:**

Comments:

Current Daily Fluid Intake (What you drink on a typical day)

Water:	**oz. OR # of bottles:**	
Tea:	**oz.**	Reg Decaf Sweet Unsweet Diet Herbal Green
Coffee:	**oz.**	Reg Decaf Black Sugar No Cal Sweetener Milk Cream Diet Creamer
Pop:	**oz.**	Reg Diet W/Caffeine De-Caff
Milk:	**oz.**	Skim 1% 2% Whole Soy Coconut/Almond (regular or light)
Juice:	**oz.**	Regular Low Calorie Diet/Calorie Free
Sports Drinks:	**oz.**	Reg Zero Calorie
Energy Drinks:	**oz.**	Reg Diet
Alcohol:		

Current Eating Pattern Characteristics.

Do you eat when you are not hungry: Yes No

If yes: what are your triggers: (circle all that apply) stress, upset, mad/angry, happy, sad, pleasure seeking, depression, anxiety, boredom, grazing, social reasons, habit, schedule, aroma, taste, visual cues (I see it, I want it), easily available, watching TV or a movie or other: ____________________________

If yes: are there foods you typically eat:________________________________

Do you binge eat (or compulsive overeating)? Yes No
(This is eating a much larger amount of food than normal and eaten in a relatively short period of time. This is often done alone, with a loss of control over the eating and sometimes you don't remember.)

If yes, how often? ____

Triggers: Emotional Not eating all day Isolation Other

Do you purge (vomit, exercise, or use laxatives) to lose weight? Yes No

How would you describe your hunger/eating habits? **(circle those that apply)**
I'm often not hungry   I'm always hungry   I skip meals   I usually eat when I'm hungry

How would you describe your portion sizes? Large Medium Small

How often do you clean your plate? Always Sometimes Never

Do you overeat? Always Sometimes Never

How fast do you usually eat?
Fast   Moderate   Slow   Depends on the situation

Do you chew your food to applesauce consistency? Always Sometimes Never

How often do you eat fast food?
Almost never   1-3 times a week   4-7 times a week   more than 7 times a week

How often do you eat sit down restaurant food?
Almost never   1-3 times a week   4-7 times a week   more than 7 times a week

Questions for the Dietitian?