

**PATIENT INFORMATION** NOTE: In order to be seen at this facility, patients under age 18 must have a parent/guardian sign a Consent and Authorization form.

**Name (last, first):** \_\_\_\_\_ **UF ID:** \_\_\_\_\_

Other Names/Aliases, Preferred Pronouns (optional): \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_ **Age:** \_\_\_\_\_ **Sex:**  Male  Female **Gender Identity (optional):** \_\_\_\_\_  
(MM/DD/YYYY)

**I live:**  On Campus  Off Campus **Year In School:**  Freshman  Sophomore  Junior  Senior  Grad Student

**Major:** \_\_\_\_\_

**Referred by:**  Self  RecSports  Health Care Provider  Other: \_\_\_\_\_

**Have you seen a Nutritionist/Registered Dietitian before?**  Yes  No If so, who and when? \_\_\_\_\_

**Why do you want to see a nutritionist?** Check all that apply.

- |                                                          |                                                     |                                       |
|----------------------------------------------------------|-----------------------------------------------------|---------------------------------------|
| <input type="checkbox"/> Anemia                          | <input type="checkbox"/> High cholesterol           | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Diabetes                        | <input type="checkbox"/> Irritable bowel syndrome   | _____                                 |
| <input type="checkbox"/> Disordered eating concerns      | <input type="checkbox"/> Vegetarian or vegan eating | _____                                 |
| <input type="checkbox"/> General healthy eating concerns | <input type="checkbox"/> Want to gain weight        |                                       |
| <input type="checkbox"/> High blood pressure             | <input type="checkbox"/> Want to lose weight        |                                       |

**MEDICAL HISTORY**

Are you currently being treated for a medical condition?  Yes  No  Not Sure

If yes, please explain: \_\_\_\_\_

Are you taking any prescription medications, over-the-counter medications, vitamins and/or supplements?  Yes  No  Not Sure

If yes, please list: \_\_\_\_\_

Do you have any family history of diabetes?  Yes  No  Not Sure

If yes, please explain: \_\_\_\_\_

Do you have any family history of high blood pressure?  Yes  No  Not Sure

If yes, please explain: \_\_\_\_\_

Do you have any family history of high cholesterol?  Yes  No  Not Sure

If yes, please explain: \_\_\_\_\_

**QUESTIONS**

1. Height: \_\_\_\_\_ feet \_\_\_\_\_ inches Present weight: \_\_\_\_\_ pounds Usual weight: \_\_\_\_\_ pounds  
Weight when graduated high school: \_\_\_\_\_ pounds Desired weight range: \_\_\_\_\_ pounds to \_\_\_\_\_ pounds

2. How often do you weigh yourself?  More than once a day  Daily  Almost Daily  Weekly  Rarely  Never

3. Have you ever had concerns about your weight?  Yes (If yes:  Overweight  Underweight)  No

Comments: \_\_\_\_\_

4. Which of the following best describes your family?

- |                                                                                         |                                                                                         |
|-----------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|
| <input type="checkbox"/> As a group, my family is not overweight or obese.              | <input type="checkbox"/> As a group, most members of my family are overweight or obese. |
| <input type="checkbox"/> As a group, some members of my family are overweight or obese. | <input type="checkbox"/> I am not sure.                                                 |

5. How would you generally describe your eating habits?  Good  Fair  Poor

6. How often do you eat fewer than 3 times a day?  Daily  Almost Daily  Weekly  Rarely  Never

7. Does your food intake or weight feel out of control?  Yes  No

8. How would you rate your appetite recently?  Hearty  Normal  Moderate  Poor

9. How many times a day do you have a meal or snack?  0-3 times  3-5 times  5 or more

Describe your typical snack or meal: \_\_\_\_\_  
\_\_\_\_\_

10. On average, how much water do you consume each day?  0-16 oz.  16-32 oz.  32-48 oz.  48-64 oz.  64 oz. or more

11. On average, how many days per week do you consume alcoholic drinks? Circle your answer. 0 1 2 3 4 5 6 7

12. How many drinks do you consume when you drink? (1 drink= 1.5 oz. of 80 proof liquor, 5 oz. wine, or 12 oz. beer)

Do not drink  1-2 drinks  3-5 drinks  6-8 drinks  9 or more drinks

13. Do you have food allergies?  Yes  No  Not Sure

If yes, list foods you are ALLERGIC to: \_\_\_\_\_

14. Are you on a special diet?  Yes  No Who prescribed or suggested this diet for you?  Doctor  Friend  Family  Self

Please specify type:  Vegetarian  Low-carb  Diabetic  Gluten-free  Other: \_\_\_\_\_

15. How many meals do you eat per week: At home: \_\_\_\_\_ Dining hall: \_\_\_\_\_ Restaurant: \_\_\_\_\_ Work: \_\_\_\_\_

Fast food chain: \_\_\_\_\_ Sorority/Fraternity: \_\_\_\_\_ Other: \_\_\_\_\_

16. How many days per week do you participate in moderate to vigorous activity (brisk walking, jogging or aerobics) for at least 10 minutes?

Circle your answer. 0 1 2 3 4 5 6 7

17. On days you do moderate to vigorous activity, how much total time do you spend?  10-30 mins  30-60 mins  60 mins or more

18. What do you hope to achieve as a result of nutrition counseling? \_\_\_\_\_  
\_\_\_\_\_

19. Please circle your answers on the 1-5 scale:

**Not At All**

**Extremely**

**How important is change to you?** 1 2 3 4 5

**How confident are you to make this change at this time?** 1 2 3 4 5

20. What barriers, if any, stand in the way of you achieving your nutritional goals? Check all that apply.

Time  Hunger  Stress  Influence of others  Money  Don't like to exercise  Not sure what to eat  Not a priority

Lack of motivation  Other, please list: \_\_\_\_\_

**24 HOUR FOOD RECORD**

Please provide a list of ALL food and beverages you ate in a 24-hour time period. Try to be as specific as possible: Indicate food that is homemade or give the name of the restaurant or brand, as well as specifying portion sizes (for example: 1 cup, 1 slice or 1 handful). PLEASE USE THE BACK OF THIS SHEET AS NEEDED.

**BREAKFAST – # TIMES / WEEK: 0 1 2 3 4 5 6 7**

**SNACK**

**SNACK**

**DINNER – # TIMES / WEEK: 0 1 2 3 4 5 6 7**

**LUNCH – # TIMES / WEEK: 0 1 2 3 4 5 6 7**

**SNACK**