

# Medical Nutrition Therapy Intake Form

## General Information:

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Gender: \_\_\_\_\_

Reason for Appointment: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Primary Care Provider: \_\_\_\_\_

Address: \_\_\_\_\_

Therapist: \_\_\_\_\_

Address: \_\_\_\_\_

Employment Status:     Full Time                       Part time                       Not Employed

Place of Employment/Type of Work: \_\_\_\_\_

Education level:             Grammar school             High school             College             Graduate School

Grade in School: \_\_\_\_\_ Name of School: \_\_\_\_\_

Marital status:             Single             Married             Divorced             Separated             Widow

Significant Relationship:  Boyfriend                       Girlfriend

Parent's marital status:  Single             Married             Divorced             Separated             Widow

Parent's occupation(s): \_\_\_\_\_

Siblings:                      \_\_\_ Brother(s)            \_\_\_ Sister(s)

Number of Children: \_\_\_\_\_

## Medical History:

Height: \_\_\_\_\_ Growth History: \_\_\_\_\_

Current Wt: \_\_\_\_\_ Wt 1 year ago: \_\_\_\_\_ Usual Wt: \_\_\_\_\_

Lowest Wt: \_\_\_\_\_ Highest Wt: \_\_\_\_\_ Desired Wt: \_\_\_\_\_

Have you recently lost/gained wt?  Yes                       No                      Amount: \_\_\_\_\_

Was this an intentional change?  Yes                       No

Do you weigh yourself?  Yes                       No                      How often? \_\_\_\_\_

Are you concerned with your weight?  Yes                       No

Birth weight: \_\_\_\_\_ Breast fed? \_\_\_\_\_ How long? \_\_\_\_\_

Mother's Height: \_\_\_\_\_ Father's Height: \_\_\_\_\_

*Please indicate whether you or a family member have/had any of the following conditions:*

<b>Disease/Condition</b>	<b>Self</b>	<b>Family</b>	<b>Relationship</b>	<b>Treatment</b>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Cardiovascular Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Obesity	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Intestinal problems	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Menstrual problems	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Food Allergies	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Food Intolerances	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Mental Health Issues	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Drug Dependency	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Other	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

Are you currently being treated for any medical conditions: Yes No

Please Specify: \_\_\_\_\_

List any medications you are currently taking or have taken in the last year: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Are you currently taking any food or nutritional/herbal supplements? Yes No

Please Specify: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Has your doctor recommended you follow a special diet? Yes No

Please Specify: \_\_\_\_\_

Are you currently following this diet? Yes No

If not, please indicate why; If yes, indicate what changes you are making: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Do you drink alcohol? Yes No Number of drinks/wk: \_\_\_\_\_  
 Do you smoke cigarettes? Yes No Amount/day: \_\_\_\_\_  
 How long have you smoked? \_\_\_\_\_ If you quit smoking, when? \_\_\_\_\_  
 Do you use drugs? Yes No Explain: \_\_\_\_\_

**Menstrual History:**

Are you currently menstruating: Yes No Have never menstruated  
 Age began menstruating: \_\_\_\_\_ years of age  
 Date of last menstrual cycle: \_\_\_\_\_ Weight at that time: \_\_\_\_\_ pounds  
 Are you taking birth control pills/estrogen pills? Yes No  
 Do you experience PMS? Yes No  
 Symptoms: \_\_\_\_\_

**Dieting History**

How many times have you tried to lose weight? \_\_\_\_\_  
 Age of first attempt: \_\_\_\_\_ years Your weight at that time: \_\_\_\_\_ pounds  
 What did you do? \_\_\_\_\_  
 Why did you go on the diet? \_\_\_\_\_  
 \_\_\_\_\_

**Have you ever used any of the following for weight control?**

Commercial diet programs	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Liquid diets	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Fad diets	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Prescription diet pills	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Over-the-counter diet pills	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Laxatives	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Diuretics	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Ipecac Syrup	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Vomiting	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Self Designed program	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Other	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____

Do you experience periods in which you eat uncontrollably? Yes No

If yes, how often? \_\_\_\_\_

At what age did this begin? \_\_\_\_\_ years

Is this followed by:

<input type="checkbox"/> Vomiting	Age began: _____	How often: _____
<input type="checkbox"/> Laxative use	Age began: _____	How often: _____ Amount: _____
<input type="checkbox"/> Excessive exercising	Age began: _____	How often: _____
<input type="checkbox"/> Self Harm	Age began: _____	How often: _____
<input type="checkbox"/> Negative Emotions	Age began: _____	How often: _____
<input type="checkbox"/> Other (explain)	_____	

Have you ever been diagnosed with an eating disorder? Yes No

Please Explain: \_\_\_\_\_

Are you currently or have you ever received treatment? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Do you currently restrict food for weight control? Yes No

Please Explain: \_\_\_\_\_

Do you currently exercise for weight control? Yes No

Please Explain: \_\_\_\_\_

### ***Exercise History:***

Are you currently exercising: Yes No

List type, duration, frequency, and intensity of exercise activities:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Have you exercised in the past year? Yes No

List type, duration, frequency, and intensity of exercise activities:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Do you have any physical conditions that limit your ability/safety to exercise? Yes No

Please Specify: \_\_\_\_\_

### ***Family Weight History:***

Are any members of your family overweight? Yes No

Explain: \_\_\_\_\_

Are any members of your family underweight? Yes No

Explain: \_\_\_\_\_

Did/Does anyone in your family diet? Yes No

Explain: \_\_\_\_\_

Did/Does anyone in your family have an eating disorder? Yes No

Explain: \_\_\_\_\_

Does your family eat meals together? Yes No

What meals? \_\_\_\_\_

What is this like? \_\_\_\_\_



**Eating Habits:**

Do you regularly skip meals? Yes No

How many days/wk do you eat Breakfast:\_\_\_\_\_ Lunch:\_\_\_\_\_ Dinner:\_\_\_\_\_ Snacks:\_\_\_\_\_

When do you usually snack? \_\_\_\_\_

Do you buy or pack your lunches: Buy # days/week:\_\_\_\_\_ Pack # days/week: \_\_\_\_\_

Do you eat out? Yes No

How often? \_\_\_\_\_

Do you order take out? Yes No

How often? \_\_\_\_\_

Do you eat fast food? Yes No

How often? \_\_\_\_\_

List restaurants you usually choose: \_\_\_\_\_

Who does the grocery shopping? \_\_\_\_\_

Who prepares/cooks the meals? \_\_\_\_\_

Do you read food labels? Yes No

What do you look at on the label? \_\_\_\_\_

Do the nutrition facts influence your decision to eat the food? Yes No

Do you eat standing up? Yes No

Do you eat in the car? Yes No

Do you eat in front of the tv? Yes No

Do you eat while reading, on the computer, etc? Yes No

Do you eat with others? Yes No

Do you eat faster/slower than others? Yes No

Do you eat when you are stressed? Yes No

Do you eat when you are bored? Yes No

Do you eat when you are anxious? Yes No

Do you eat when you are lonely? Yes No

Do you eat when you are not hungry? Yes No

Do you know what hunger & fullness feel like? Yes No

Do you prepare your own meals? Yes No

Do you avoid certain foods? Yes No

Please Specify: \_\_\_\_\_

What are your favorite foods? \_\_\_\_\_

What food don't you like? \_\_\_\_\_

**Food Intake Checklist:**

Check what foods you consume. Briefly indicate frequency, amounts, and brands.

	Amount/Brand	Daily	Weekly	Monthly	Never
<b>Example:</b>					
Yogurt	1 cup/ Dannon Light	✓	(3 times a week)		
Milk					
Cheese					
Yogurt					
Fruits					
Vegetables					
Red meat					
Poultry					
Fish					
Seafood					
Pork					
Eggs					
Nuts					
Cold cuts					
Soy foods					
Starchy beans					
Bread					
Pasta					
Rice					
Cereal					
Muffins					
Candy					
Cookies					
Desserts					
Fried foods (french fries, etc)					
Potato chips					
Soda, Snapple, Sobe					
Juice					
Butter, Margarine					
Salad dressing					
Other fats					
Other:					

**Malnutrition Signs/Symptoms:**

*Please check if you now, or have ever, experience any of the following:*

- Irregular menstrual periods
- Absent menstrual periods
- Cold intolerance
- Tingling sensation in hands or feet
- Headaches
- Lightheadedness/ Dizziness
- Fainting
- Sleeping difficulties
- Skin changes
- Hair loss
- Hair growth on face and/or chest
- Chest pains
- Rapid heart beat
- Shortness of breath
- Mood Swings
- Episodes of crying for “no reason”
- Frequently thinking about food
- Confusion
- Difficulty concentrating
- Anxiety, especially around food
- Less social interaction with family
- Less social interaction with friends
- Frequently tired
- Memory problems
- Difficulty making decisions
- Problems with teeth
- Sore throat
- Swollen parotid glands
- Taste changes
- Constipation
- Diarrhea
- Muscle pain
- Joint pain
- Obsessive-compulsive behaviors
- Feelings of depression
- Other: \_\_\_\_\_

**Disordered Eating Behaviors:**

*Please check if you experience any of the following:*

- Count calories
- Count fat grams /sugar grams/ carbohydrate grams/ protein grams
- Avoid eating a food if you do not know how it was prepared
- Avoid eating a food if you do not know it's nutritional content
- Cut your food into small pieces
- Weigh/ measure your food
- Refuse to eat after certain hour
- Won't eat unless you are able to exercise or purge afterward
- Eat the same foods daily
- Are scared to try new foods
- Won't eat in front of others
- Hide food so others will think you ate it
- Hide food so you can binge
- Feel guilty after eating
- Eat foods that are different from the rest of your family
- Believe there are good foods and bad foods
- Feel ashamed of your eating
- Become upset if you are unable to eat at a certain time
- Become upset if you eat foods other than what you planned
- Feel food is controlling your life

**Client's Impressions:**

Do you feel that you have a problem with food and eating?    Yes            No

Is this something that you want to work on changing?    Yes            No

What are your goals? Please list and prioritize with #1 as most important.

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