MelanieJatsek
Dare to be diet free... and healthy!

Historical Data & Diet History Questionnaire

General Information:

Name: ______________________________ Date: __________________
Address: ____
Phone: ______________________ Email: __________________________
Age: ___________ Date of Birth: __________________

Reason for Appointment:
____
____

Primary Care Provider: ____

Employment Status: ❑ Full Time ❑ Part time ❑ Not Employed
Place of Employment/Type of Work: ______________________________________

Medical History:

Have you recently lost/gained weight? ❑Yes ❑No
Was this an intentional change? ❑ Yes ❑ No
Do you weigh yourself? ❑Yes ❑ No How often? __________
Are you concerned with your weight? ❑Yes ❑No Why? ___________________

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

Disease/Condition	Self	Family	Relationship	Treatment
Diabetes	____	____	___________________	
Kidney Disease	____	____	___________________	
Cardiovascular Disease	____	____	___________________	
Heart Attack	____	____	___________________	
Hypertension	____	____	___________________	
High Cholesterol	____	____	___________________	
Cancer	____	____	___________________	
Intestinal problems	____	____	___________________	
Menstrual problems	____	____	___________________	
Osteoporosis	____	____	___________________	
Food Allergies	____	____	___________________	
Food Intolerances	____	____	___________________	
Mental Health Issues	____	____	___________________	
Drug Dependency	____	____	___________________	
Asthma	____	____	___________________	
Headaches	____	____	___________________	
Other	____	____	___________________	

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/week: ________________
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: ___________________________

Dieting History:

How many times have you tried to lose weight? ________
Age of first attempt: ______year 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?

	Yes	No	Please Explain
Commercial diet programs	____	____	____________________
Liquid diets	____	____	____________________
Fad diets	____	____	____________________
Prescription diet pills	____	____	____________________
Over-the-counter diet pills	____	____	____________________
Laxatives	____	____	____________________
Diuretics	____	____	____________________
Vomiting	____	____	____________________
Self-Designed program	____	____	____________________
Other	____	____	____________________

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:

- ❑ Vomiting
- ❑ Laxative use
- ❑ Excessive exercising
- ❑ Self Harm
- ❑ Negative Emotions
- ❑ 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: ____

Lifestyle:

Please list your current stresses: ____
____
____

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Please describe what a typical day is like for you from when you wake until you go to bed (list activities, meals and times but do not go into detail with what you eat):

____
____
____
____
____
____
____

How do weekends differ?

____
____
____
____

Eating Habits:

Do you regularly skip meals? ❑Yes ❑No
How many days/week 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? ____

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 you eat in front of the t.v.? ❑ Yes ❑No
Do you eat while reading, on the computer, etc? ❑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 avoid certain foods? ❑Yes ❑No

Please specify: ____

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

- ❑ Irregular or 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/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: ____

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
- ❑ Weigh/measure your food
- ❑ Refuse to eat after a 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 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