Name: _____DOB:_____ Sex: M/F

How did you hear about us?_____

Have you ever seen a dietician before? Yes/No If so, when?_____

What are your reasons for wishing to see a Dietitian?

_____

_____

_____

What are you short- and long-term health goals?

_____

_____

_____

Food & Eating Attitudes and Behaviours

Do any of these apply to you?

☐Eating too much sugar	☐Eat too fast	☐Skip meals often
☐No Exercise	☐Consume juice/teas/sodas	☐Eat when not hungry
☐Drink Diet Beverages	☐Eat frozen meals	☐Have food allergies
☐Consume too much salt	☐Eat little/no fruit or vegetables	☐Eat a lot of takeout
☐Consume caffeinated drinks	☐Eat too much fatty foods	☐Use sugar substitutes
☐Eat a lot of junk food	☐Don't drink enough water	☐Avoid food groups

Do you believe you overeat or undereat?

_____

What do you believe triggers these habits?

_____

_____

_____

What food do you usually crave?

_____

_____

_____

When do you experience these cravings?

_____

Do you feel you have a positive body image?_____

_____

What is your favourite meal of the day?

_____

_____

What would your favourite meal be?

_____

_____

About Your Lifestyle

Are you active?

Please complete the table

Activity	Number of Days a Week	Duration

Do you have any limitations or barriers preventing you from regular exercise?

_____

_____

How many hours do you sleep on weekdays? _____ Weekends? _____

Nutrition History

Current weight_____ Height_____ Goal weight_____

Do you have or have you had an eating disorder or disordered eating behaviour? Yes/No

If yes, please describe _____

_____

_____

How many meals do you eat per day? _____ How many snacks?_____

Who does the shopping and cooking in your household?

_____

How many times a week would you eat out/order in?

_____

Why do you choose to eat out/order in?

_____

_____

Do you read food labels?_____ Do you understand food labels?_____

Do you drink alcohol? Yes/No If yes, how many times per week _____

Do you smoke? Yes/No

Are you currently taking any vitamins/minerals? Please list

_____

_____

_____

Are you taking medication? Please list them

_____

_____

For office use only

Reviewed By: _____ Date: _____

Notes: _____

_____

_____