Nutrition History

Virtua
Center for Weight Management

Please answer each of the questions below. The information you share will help your dietitian have a better understanding of your needs.

Client: _____ Date: _____

1. What are your primary goals in seeing a dietitian?

_____

_____

2. What would make this experience most successful for you?

_____

_____

3. What was your lowest adult weight? _____ pounds What was your age at this weight? _____

   What was your highest adult weight? _____ pounds What was your age at this weight? _____

4. What are some of your non-weight related health or physical activity goals?

_____

_____

5. Have you ever tried to lose weight in the past?

   - ❑ No *(skip to question 10)*
   - ❑ Yes, I have tried these diets / medications: _____

6. If yes to question 5, did you lose weight?
   - ❑ No
   - ❑ Yes: I lost_____ pounds over this period of time: _____

     How much of this weight, if any, did you gain back? _____ pounds

     What worked best for you? _____

     _____

7. Do you take any vitamins, minerals, herbal or other dietary supplements?
   - ❑ No
   - ❑ Yes: _____

8. In the past, have you tried to control your weight by vomiting, diet pills, laxatives, or withholding food?
   - ❑ No
   - ❑ Yes: _____

9. Please identify the frequency you consume the foods in the chart below:

Food	*Daily*	*2-4 times per week*	*Never / Rarely*
Fruits			
Vegetables			
Grains (bread, cereal, potatoes)			
Meats (beef, game, ham)			
Poultry (chicken, turkey)			
Seafood			
Soft Drinks / Sugar-sweetened beverages			
Alcohol			
Sweets (candy, cakes, pies)			

10. Please identify your participation in any physical activities, if any, in the chart below:

Which activities do you participate in weekly?	*How many times per week do you do this activity?*	*How much time do you spend in this activity in a typical week?*

Please indicate your answers to the questions below by putting an X on the appropriate line.
Note: Lifestyle changes are behaviors that will improve your health such as adjusting your diet, increasing physical activity, and/or changing health-related behaviors

11. How important it is for you to make positive lifestyle changes?

.....

0	**5**	**10**
Not very important	*Somewhat important*	*Very important*

12. How ready are you right now to make positive lifestyle changes?

.....

0	**5**	**10**
Not very ready	*Somewhat ready*	*Very ready*

13. How confident you are in your ability to make positive lifestyle changes?

.....

0	**5**	**10**
Not very confident	*Somewhat confident*	*Very confident*

14. How would you rate your current level of stress?

.....

0	**5**	**10**
Very relaxed	*Managing OK*	*Very stressed*

14. What barriers, if any, may make it difficult for you to make positive lifestyle changes?

_____

_____

Please bring completed this completed form with you to your first appointment.

Thank you for allowing us to be a part of your jumpstart to wellness!
We are very glad you chose Virtua to help you be well, get well, and stay well!

April, Bonnie, Lauren, and Valerie
Your Wellness Nutrition Team