Virtua
Center for Weight Management

Nutrition History

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. Are you concerned about your weight?
   - ☐ No *(skip to question 4)*
   - ☐ Yes, I want to stop gaining weight *(skip to question 4)*
   - ☐ Yes, I want to lose weight

2. What do you think weighing less will do for you?

   In the next few months: _____

   _____

   In the next year or two: _____

   _____

3. What is your goal weight? _____ pounds

4. What was your lowest adult weight? _____ pounds Age at this weight? _____

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

5. Do you take any vitamin, mineral, herbal or other dietary supplements (for example protein powders)?
   - ☐ No
   - ☐ Yes: _____

6. Are you currently on a diet or taking prescribed or over-the-counter diet pills?
   - ☐ No
   - ☐ Yes, I am (explain): _____

   _____

   _____

7. Have you tried to lose weight in the past?
   - ☐ No *(skip to question 10)*
   - ☐ Yes, I have tried these diets / medications: _____

   _____

   _____

8. If yes to question 7, did you lose weight?
   - ☐ No
   - ☐ Yes: _____ pounds over this period of time: _____

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

   What worked best for you and why? _____

   _____

   _____

9. In the past year, have you tried to lose weight or control your weight by vomiting, taking diet pills, taking laxatives, or not eating?
   - ☐ No
   - ☐ Yes

10. Do you ever feel that your eating is out of control?
    - ☐ No
    - ☐ Yes (explain): _____

    _____

11. Do you participate in regular physical activity?
    - ☐ No *(skip to question 13)*
    - ☐ Yes *(fill in 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?*
1.		
2.		
3.		
4.		

12. Put an X on the line below to show, on a scale of 0-10, how important it is for you to make positive lifestyle changes. *(Lifestyle changes are changes to improve your health such as adjusting your diet, increasing physical activity, and/or changing health-related behaviors)*

.....

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

13. Put an X on the line below to show how ready you are right now to make positive lifestyle changes.

.....

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

14. Put an X on the line below to show how confident you are in your ability to make positive lifestyle changes.

.....

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

15. What lifestyle changes would you be willing to make? _____

_____

_____

16. How much time would you be willing to spend each week on making lifestyle changes? *(For example, reading information, tracking foods eaten, physical activity)*

_____

17. What things might make it hard for you to make lifestyle changes?

_____

_____

18. Put an X on the line below to show your current level of stress.

.....

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

19. Please describe your family – number of people you live with and their relationship to you.

- ☐ I live alone
- ☐ I live with my husband, wife, or partner
- ☐ I live with my _____ children, ages: _____
- ☐ Other (please describe): _____

20. Check any that apply.

- ☐ I prepare foods and/or eat alone
- ☐ My family eats most meals together
- ☐ My family is supportive of my efforts to lose weight
- ☐ Another member of my family/household is trying to lose weight

21. Check the types of food you and your family eats and how many times in a typical week you eat them.

- ☐ Heat and serve (microwave) meals: _____
- ☐ Home cooked meals: _____
- ☐ Fast foods: _____
- ☐ Restaurant meals (take out, dine out): _____

Please check to be sure you answered all questions. Thank you!