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Family Dietitian

New Patient
Nutrition Assessment Form

All information received on this form will be treated as strictly confidential. Please fill out the form ***completely and accurately***. This information is essential to helping the dietitian to develop a wellness program that addresses your needs, goals and interests and is safe and effective.

Appointment Date and Time:_____

Primary Care Physician: _____

Referring Physician: _____

Demographics						
First Name		Middle Name			Last Name	
Date of Birth		Age		Gender	☐ Male ☐ Female	
Mailing Address						
City, State, Zip Code						
Preferred Phone				☐ Home ☐ Work ☐ Mobile		
Secondary Phone				☐ Home ☐ Work ☐ Mobile		
Email Address						
Referred By						

Concerns
What health and/or nutrition concerns would you like to focus on during your visit?
1.
2.
3.

Medical History

Please check "yes" for the health conditions that your doctor has diagnosed, and then record the approximate date of onset.

CONDITION	Yes	Date of Onset	CONDITION	Yes	Date of Onset
GASTROINTESTINAL			**INFLAMMATORY / AUTOIMMUNE**		
Irritable Bowel Syndrome	☐		Chronic Fatigue Syndrome	☐	
Inflammatory Bowel Disease	☐		Rheumatoid Arthritis	☐	
Crohn's Disease	☐		Lupus SLE	☐	
Ulcerative Colitis	☐		Frequent Infections	☐	
Celiac Disease	☐		Severe Infectious Disease	☐	
Gastric or Peptic Ulcer Disease	☐		Herpes	☐	
GERD, reflux / heartburn	☐		Gout	☐	
Hepatitis C or Liver Disease	☐		Other:	☐	
Food Intolerance	☐				
Other:	☐				
RESPIRATORY			**MUSCULOSKELETAL / PAIN**		
Asthma	☐		Osteoarthritis	☐	
Chronic Sinusitis	☐		Chronic pain	☐	
Sleep Apnea	☐		Fibromyalgia	☐	
Bronchitis or Emphysema	☐		Migraines	☐	
Tuberculosis	☐		Other:	☐	
Other:	☐				
CARDIOVASCULAR			**URINARY / REPRODUCTIVE**		
Heart Disease / Heart Attack	☐		Kidney Stones	☐	
Stroke	☐		Urinary Tract Infections	☐	
Elevated Cholesterol	☐		Yeast Infection	☐	
Irregular Heart Rate	☐		Prostate Problem	☐	
High Blood Pressure	☐		Other:	☐	
Other:	☐				
NEUROLOGICAL / BRAIN			**METABOLIC / ENDOCRINE**		
Depression	☐		Type 1 Diabetes	☐	
Anxiety	☐		Type 2 Diabetes	☐	
Bipolar disorder	☐		Metabolic syndrome	☐	
ADD/ADHD	☐		Hypoglycemia	☐	
Multiple Sclerosis	☐		Hypothyroidism	☐	
Seizures	☐		Hyperthyroidism	☐	
Anorexia Nervosa	☐		Polycystic Ovarian Syndrome	☐	
Bulimia	☐		Infertility	☐	
Unspecified Eating Disorder	☐		Other:	☐	
Parkinson's Disease	☐				
Other:	☐				
DERMATOLOGICAL			**CANCER: Please list type(s) and treatments.**		
Eczema	☐				
Psoriasis	☐				
Acne	☐				
Other:	☐				

Additional health conditions your doctor has diagnosed:

Please list any previous injuries, surgeries, and hospitalizations. Provide your age and date if known.

Your Birth History: ☐ Vaginal ☐ C-section

Were you breastfed as an infant? ☐ Yes ☐ No

Family History

Have any of your close relatives (parent, sibling, child grandparent) been diagnosed with the following? Please check, describe, and provide age of onset for those that apply.

Condition	Yes	Family Member(s)	Age of Onset	Description
Heart Disease	☐			
High Blood Pressure	☐			
Stroke	☐			
Diabetes	☐			
Cancer	☐			
Overweight	☐			
Food Intolerance	☐			
Autoimmune Disease	☐			

Oral History

Do you visit a dentist twice per year? ☐ Yes ☐ No

Do you have any silver/mercury amalgam fillings? ☐ Yes ☐ No If yes, how many?

Allergies		Allergic Symptoms Experienced
Food		
Medication		
Supplement		
Environmental		

Medications and Supplements: Please list all prescription medications, nutritional supplements, and herbs/botanicals you are currently taking.
If this information is already in the Duke Medical System, you do not need to complete this section.

Medication Name	Year Started	Dose	Frequency	Reason
Herb/Supplement	**Year Started**	**Dose**	**Frequency**	**Reason**

Have you had prolonged or regular use of NSAIDS (Advil, Aleve, etc.), Motrin, Aspirin? ☐ Yes ☐ No

Have you had prolonged or regular use of Tylenol? ☐ Yes ☐ No

Have you had prolonged or regular use of acid-blocking drugs (Zantac, Pepcid, etc.)? ☐ Yes ☐ No

Have you taken antibiotics > 3 times per year? ☐ Yes ☐ No

Have you been on antibiotics long term (> 1 month continuously)? ☐ Yes ☐ No

Lifestyle Information

Do you engage in physical activity on a regular basis? ☐ Yes ☐ No If yes, complete the table below

Activity	Number of Days per Week	Duration (minutes) per Session

How many hours do you sleep on weeknights? ☐ < 6 ☐ 6-8 ☐ 8-10 ☐ 10 +

How many hours do you sleep on weekends? ☐ < 6 ☐ 6-8 ☐ 8-10 ☐ 10 +

Check which apply to you: ☐ Trouble falling asleep ☐ Wake up during the night ☐ Don't feel rested

How do you handle stress? What helps you relax?

Environmental Exposures

What is your occupation?

Are you regularly exposed to any of the following?

☐ Cigarette smoke ☐ Paint fumes ☐ Perfumes ☐ Nail Polish
☐ Auto exhaust / fumes ☐ Chemicals ☐ Dry-cleaned clothes ☐ Hair dyes

Do you feel dizzy or get a headache when exposed to strong chemical odors or fumes? ☐ Yes ☐ No
If yes, please explain.

Please describe any significant past or present exposure to substances such as recreational drugs, alcohol, or chemicals.

Nutrition History

Have you ever had an appointment with a dietitian or nutritionist? ☐ Yes ☐ No

Have you changed your eating habits for a health reason? ☐ Yes ☐ No Please describe.

Are you currently following a particular diet or nutrition plan? ☐ Yes ☐ No Please describe.

Do you avoid any particular foods? ☐ Yes ☐ No

Please explain.

Nutrition History (continued)

Do you have any adverse food reactions (intolerances or allergies)? ☐ Yes ☐ No Please explain.

Height:	Current Weight:	Usual Weight Range:	Desired Weight:

Have you recently lost or gained weight? ☐ Yes ☐ No If yes, please describe.

Do you have or have you had an eating disorder? ☐ Yes ☐ No If yes, please describe.

How many meals do you eat each day?	How many snacks do you eat each day?

How many meals do you buy from a restaurant or fast food **per week?** ☐ 0-1 ☐ 2-3 ☐ 4-6 ☐ > 6

Do you drink alcohol? ☐ Yes ☐ No If yes, how many drinks **per week?**

Do you drink caffeinated beverages? ☐ Yes ☐ No If yes, how many cups **per day?**

Do you use any natural or artificial sweeteners? ☐ Yes ☐ No If yes, which ones?

What is your favorite meal?

Check all of the factors that apply to your eating habits and current lifestyle:

☐ Love to eat
☐ Love to cook
☐ Emotional eater
☐ Late night eater
☐ Struggle with eating issues
☐ Family members have different tastes
☐ Dislike cooking
☐ Fast eater
☐ Erratic eating patterns
☐ Eat too much
☐ Rely on convenience foods
☐ Eat fast food frequently
☐ Make poor snack choices
☐ Confused about food/nutrition
☐ Live alone or eat alone often
☐ Do not plan meals or menus
☐ Time constraints
☐ Travel frequently
☐ Eat only because I have to
☐ Negative relationship with food
☐ Dislike healthy food
☐ Don't know how to cook

Food Diary: Please record what you eat and drink during one typical day (24 hour period).
Please be sure to include all beverages, cream and sweetener added to beverages, and condiments added to foods.

Time woke up:		Bedtime:	
Time	Food / Beverage Items	Amount (e.g. cups, oz., tsp)	Location (Home/Away)

Food Frequency Questionnaire – How often do you eat the following?						
Food	**Never or <4x/year**	**Rarely or <4x/month**	**Once/wk**	**2x/wk**	**3x/wk**	**Daily**
Cheese	☐	☐	☐	☐	☐	☐
Yogurt, Kefir	☐	☐	☐	☐	☐	☐
Cow's Milk	☐	☐	☐	☐	☐	☐
Milk Substitute (soy, coconut, almond, rice, or hemp seed milk)	☐	☐	☐	☐	☐	☐
Red Meat	☐	☐	☐	☐	☐	☐
Pork (pork loin, pork roast, pork chops, barbecue)	☐	☐	☐	☐	☐	☐
Processed Meat (sausage, bacon, lunch meat)	☐	☐	☐	☐	☐	☐
Chicken	☐	☐	☐	☐	☐	☐
Eggs	☐	☐	☐	☐	☐	☐
Cold Water Fish (*striped bass, wild Alaskan salmon, herring, sardines, anchovies, mackerel, Alaskan halibut, Alaskan cod)*	☐	☐	☐	☐	☐	☐
Other fish or shellfish- Indicate type:	☐	☐	☐	☐	☐	☐
Beans, Legumes (black beans, kidney beans, white beans, lentils)	☐	☐	☐	☐	☐	☐
Whole Soy Foods (edamame, soy nuts)	☐	☐	☐	☐	☐	☐
Tofu, Tempeh	☐	☐	☐	☐	☐	☐
Soy "meat alternative" (ex. Tofurkey, soy "sausage", soy "bacon")	☐	☐	☐	☐	☐	☐
Berries	☐	☐	☐	☐	☐	☐
Other Fruits- Indicate type:	☐	☐	☐	☐	☐	☐
Cruciferous Vegetables (cabbage, broccoli, Brussels sprouts)	☐	☐	☐	☐	☐	☐
Green Leafy Vegetables (e.g. spinach, kale, collards, greens)	☐	☐	☐	☐	☐	☐
Yellow Fruits and Vegetables (e.g. yellow peppers, corn)	☐	☐	☐	☐	☐	☐
Other Green Fruits and Vegetables (e.g. peas, broccoli, avocado, cucumbers)	☐	☐	☐	☐	☐	☐
Blue/Purple Fruits and Vegetables (e.g. blueberries, prunes, beets, purple cabbage)	☐	☐	☐	☐	☐	☐
Red Fruits and Vegetables (e.g. cherries, apples, tomatoes, kidney beans)	☐	☐	☐	☐	☐	☐
Orange Fruits and Vegetables (e.g. orange, cantaloupe, carrots, sweet potato)	☐	☐	☐	☐	☐	☐
White/Tan Fruits and Vegetables (e.g. onions, garlic, ginger, nuts)	☐	☐	☐	☐	☐	☐
Turmeric, Cumin, Ginger, Rosemary, Oregano, Parsley	☐	☐	☐	☐	☐	☐
Nuts, Nut Butters- Indicate type:	☐	☐	☐	☐	☐	☐
Avocado, Extra Virgin Olive Oil , Canola Oil	☐	☐	☐	☐	☐	☐
Vegetable oil (corn, sunflower, safflower, etc. – NOT olive oil)	☐	☐	☐	☐	☐	☐
Butter, ghee	☐	☐	☐	☐	☐	☐
White Rice	☐	☐	☐	☐	☐	☐
White Pasta	☐	☐	☐	☐	☐	☐
White Bread	☐	☐	☐	☐	☐	☐
Bagels	☐	☐	☐	☐	☐	☐
English Muffins	☐	☐	☐	☐	☐	☐
Pancakes or Waffles	☐	☐	☐	☐	☐	☐

Food	Never or <4x/year	Rarely or <4x/month	Once/wk	2x/wk	3x/wk	Daily
Buttermilk Biscuits	☐	☐	☐	☐	☐	☐
Chips	☐	☐	☐	☐	☐	☐
Pretzels	☐	☐	☐	☐	☐	☐
Popcorn	☐	☐	☐	☐	☐	☐
Other Snack Food (crackers, Goldfish)	☐	☐	☐	☐	☐	☐
100% Whole Wheat, Rye, Barley (whole wheat bread and pasta)	☐	☐	☐	☐	☐	☐
Other Whole Grains (millet, quinoa, amaranth, flax, oats, brown rice)	☐	☐	☐	☐	☐	☐
Ice Cream	☐	☐	☐	☐	☐	☐
Pastries, cookies, cakes	☐	☐	☐	☐	☐	☐
Juice- Indicate type:	☐	☐	☐	☐	☐	☐
Punch, Lemonade, or Sweet Tea	☐	☐	☐	☐	☐	☐
Diet Soda	☐	☐	☐	☐	☐	☐
Soda (not diet)	☐	☐	☐	☐	☐	☐
Red Wine	☐	☐	☐	☐	☐	☐
Tea (white, green, black)	☐	☐	☐	☐	☐	☐

Daily Intake Summary

What type(s) of protein do you consume most days of the week? (Check all that apply.)

☐ Animal meat ☐ Beans ☐ Eggs ☐ Soy-based ☐ Dairy ☐ Nuts and seeds

How many servings of fruit do you have in a day?	
How many servings of vegetables do you have in a day?	

Provide an estimate of the amount of each beverage that you consume on an average day.
Circle the label that is most appropriate based on how you consume the beverage.

Water: _____ ounces, cup(s)
Coffee: _____ ounces, cup(s)
Diet soda: _____ cup(s), can(s), liter(s)
Non-diet soda: _____ cup(s), can(s), liter(s)
Tea: _____ cup(s)
Other: _____

SYMPTOM SURVEY

Patient Name:_____Date:_____

Completing this form is particularly helpful if you have experienced persistent and bothersome symptoms from more than one category below. Score every symptom based on your experience over the last 30 days. Start with the first symptom and ask yourself, "Lately, have I experienced this symptom?" If you answer no or almost not at all, then write a "0" in the corresponding field. If the answer is yes, then ask yourself if you experience the symptom occasionally (less than 2 times in a week) or frequently (2 or more times in a week). After you have decided on the frequency, then ask yourself if the symptom is "Severe" or "Not Severe". Using the SCALE OF SYMPTOM POINTS listed below, write the appropriate score in the corresponding field for EVERY symptom listed. Total the points for each category, and add all category totals to come up with the Grand Total.

SCALE OF SYMPTOM POINTS:	Grand Total:
0 = Do Not Suffer From This Ever or Almost Ever 1 = Suffer OCCASSIONALLY (less than 2 times per week), is not severe 2 = Suffer FREQUENTLY (2 or more times per week), is not severe 3 = Suffer OCCASSIONALLY and is severe 4 = Suffer FREQUENTLY and is severe	

CONSTITUTIONAL

_____ Fatigue (sluggish, tired)
_____ Hyperactive (nervous energy)
_____ Restless (can't relax/sit still)
_____ Sleepiness During Day
_____ Insomnia at Night
_____ Malaise
_____ TOTAL (0-20)

EMOTIONAL/MENTAL

_____ Depression (feelings of hopelessness)
_____ Anxiety (vague fears, uneasiness)
_____ Mood Swings (rapid distinct changes)
_____ Irritability
_____ Forgetfulness
_____ Lack of concentration/focus
_____ TOTAL (0-24)

HEAD/EARS

_____ Headache (any kind)
_____ Migraine (diagnosed)
_____ Earache
_____ Ear Infection
_____ Ringing in Ear
_____ Itchy Ears
_____TOTAL (0-24)

SKIN

_____ Blemishes, Acne
_____ Rashes, Hives
_____ Eczema
_____ "Rosy" Cheeks
_____ TOTAL (0-16)

NASAL/SINUS

_____ Post Nasal Drip
_____ Sinus Pain
_____ Runny Nose
_____ Stuffy Nose
_____ Sneezing
_____ TOTAL (0-20)

MOUTH/THROAT

_____ Sore Throat
_____ Swollen Throat
_____ Swelling of Lips/Tongue
_____ Gagging/Throat Clearing
_____ Lesions ("Canker Sores")
_____ TOTAL (0-20)

LUNGS

_____ Wheezing" (Asthma or Asthma-like Symptoms)
_____ Chest Congestion
_____ Non-Productive Coughing
_____ Productive Coughing
_____ TOTAL (0-20)

EYES

_____ Red or Swollen Eyes
_____ Watery Eyes
_____ Itchy Eyes
_____ Dark Circles" or "Baggy"
_____ TOTAL (0-16)

GENITOURINARY

_____ Increased Urinary Frequency
_____ Painful Urination
_____ TOTAL (0-8)

MUSCULOSKELETAL

_____ Joint Pains/Aching
_____ Stiff Joints
_____ Muscle Aches
_____ Stiff Muscles
_____ TOTAL (0-20)

CARDIOVASCULAR

_____ Irregular Heartbeat
_____ High Blood Pressure _____ TOTAL (0-8)

DIGESTIVE

_____ Heartburn/Esoph.Reflux
_____ Stomach Pains/Cramps
_____ Intestinal Pains/Cramps
_____ Constipation
_____ Diarrhea
_____ Bloating Sensation
_____ Gas (of Any Kind)
_____ Nausea, Vomiting
_____ Painful Elimination
_____ TOTAL (0-36)

WEIGHT MANAGEMENT

_____ **Record Actual Weight**
_____ **Approximate Height**
_____ Fluctuating Weight
_____ Food Cravings
_____ Water Retention
_____ Binge Eating or Drinking
_____ Purging (all methods)
_____ TOTAL (0-20)

Comments: