DATE _____

Patient History

Name_____ Sex: M F Age:____ Birth date:_____
Address_____ Home Phone:_____
_____ Office Phone:_____
Email _____ Cell Phone: _____
Medical Notes_____
_____

Personal Information, Appetite, Eating Patterns

1. Present weight:_____ Desired weight:_____ Height:_____

   TSF (mm)_____ Goal TSF (mm)___

2. How would you describe your appetite? (Circle one)

   Hearty Moderate Poor

3. Do you eat at approximately the same time every day?_____

4. Do you skip meals?___ If yes, which meals, usually?_____

5. Do you have any eating habits you would like to change?

_____

Food Choices

1. List any foods you cannot eat. (Possible food allergies, intolerances)

   _____

   What happens when you eat these? _____

2. List any foods you do not like._____

   _____

3. List any foods you avoid because of special beliefs_____

_____

4. Are you on a special diet? If so, please specify the type_____

   _____

5. How is your food usually prepared? (Circle one):

   Baked Broiled Fried

6. Do you usually drink milk?_____ If yes, what kind?_____

Terri Lisagor, EdD, MS, RD

Weight History

1. Have you ever had any problems with weight?_____
2. How do you feel about your current weight?

Too thin Fine Too Heavy

Supplements and Medications

1. List any vitamin or mineral supplements you are taking. _____

_____

2. List any medications you take regularly._____

Exercise

1. How physically active are you? (Circle one)

Very active Active Average Inactive Very inactive

2. What do you do for physical exercise and how often do you do it?

_____

3. Circle any of the exercises you consider to be aerobic.

Behavior Habits

1. Do you help with grocery shopping?_____
2. Do you help with meal preparation?_____
3. Who determines how much you eat?_____
4. Do you help with meal clean up?_____
5. Do you eat dessert every night?_____
6. How often do you watch TV?_____
8. Do you usually snack after dinner?_____
9. At what time do you usually go to bed?_____
10. Do you usually wake up hungry?_____
11. What do you usually eat for breakfast?_____

Goals

1. What are your goals for this program?_____
2. How committed are you to accomplishing your goals?_____

Terri Lisagor, EdD, MS, RD