Medical Nutrition Therapy Intake Form

Date

Name (Last, First, MI) Date of Birth

Referring Physician: _____

What would you like to gain from meeting with a dietitian?

Have you seen a dietitian before? ☐ Yes ☐ No

If so, was it within the past 12 months? ☐ Yes ☐ No

Have you ever been told by a doctor that you have diabetes? ☐ Yes ☐ No

If yes, at what age? _____ ☐ Type I ☐ Type II

Have you ever had diabetic education by a Certified Diabetic Educator or a dietitian? ☐ Yes ☐ No

Current height: _____ Current weight: _____ Weight one (1) year ago: _____

What has been your highest non-pregnant weight? _____ Age _____

What is your lowest weight? _____ Age _____

What is your weight goal? ☐ Weight loss ☐ Weight gain ☐ Weight maintenance

Physical Activity:

In the last three (3) months, how many times per week have you participated in physical activity resulting in an elevated heart rate for **at least 30 continuous minutes**, such as jogging, swimming, rapid walking, biking, stair stepping, dancing, etc.?

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7

☐ I have a physical disability that prevents me from exercising

If you participate in physical activity, please list type(s) and duration of activity. If none, state none.

How long have you been participating in the above stated activities?

How physically active is your daily routine?

☐ Not Active ☐ Light ☐ Moderate ☐ Heavy

Do you have any kind of physical limitations? If so, please describe:

Nutrition:

Do you do the grocery shopping? ☐ Yes ☐ No ☐ Some

Do you do the cooking at home? ☐ Yes ☐ No ☐ Some

How often do you eat out during a typical week? _____ Where do you eat at? _____

Do you consume alcohol? ☐ Yes ☐ No

If yes, how often? _____

Are you allergic to any foods? ☐ Yes ☐ No

If yes, please list _____

Do you have any food intolerances/sensitivities? ☐ Yes ☐ No

If yes, please list _____

Are there certain foods that you avoid from your diet? ☐ Yes ☐ No

If yes, please explain _____

Have you ever been told by a doctor to follow a specific nutrition plan (weight loss, diabetic, low cholesterol, etc.)? ☐ Yes ☐ No

Are you currently following a nutrition plan (i.e. diabetic, gluten free, low lactose, low cholesterol, etc.) ? ☐ Yes ☐ No

If yes, please describe _____

What have been some of your health challenges/obstacles that you encountered in the past?

- ☐ Limiting sweets/desserts
- ☐ Eating too large of quantities
- ☐ Lack of motivation
- ☐ Limiting high sugar beverages
- ☐ Emotional eating (stress, upset, happy, etc.)
- ☐ Problems with goal setting
- ☐ Eating too fast
- ☐ Feeling overly hungry
- ☐ Lack of physical activity (not seeing results)
- ☐ Eating when not hungry
- ☐ Food cravings
- ☐ Chewing/swallowing
- ☐ Skipping meals
- ☐ Unsure about what to eat
- ☐ Lack of appetite
- ☐ Difficulty with shopping
- ☐ Difficulty with cooking
- ☐ Financial challenges

What changes are you ready to make within the next 30-60 days to improve your overall health?

Food and Beverage Record

Please write down everything that you eat and drink for three (3) consecutive days. Please include as much information as possible as this helps us in the evaluation and planning of your nutritional plan.

Date/Time	Location of meal	Food/Beverage Item	Quantity	How Hungry	Comments