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Data Collection Form

Name: _____ Date: _____

Address: _____

Phone: (day) _____ (evening) _____ (cell) _____

E-Mail: _____

Occupation: _____

Age: _____ Height: _____ (cm) _____ Weight: _____ (Kg) _____

BMI _____ Shaded areas are for office use.

Male/Female _____ Weight loss goal: _____

$$M = 66 + (13.7 * \text{kg}) + (5 * \text{cm}) - (6.8 * \text{years})$$

$$F = 655 + (9.6 * \text{kg}) + (1.7 * \text{cm}) - (4.7 * \text{years})$$

	*		=	
Measured Resting Energy Expenditure		Activity Factor		Total Calories

Calories to maintain / lose / gain weight

Personal Meal Plan Daily Totals

	Starch		g Carbohydrate		%
	Vegetable				
	Fruit		g Protein		%
	Milk				
	Meat (Protein)		g Fat		%
	Fat				

Nutrition Summary Sheet

Reason for nutrition
counseling _____

Primary Care Physician Name _____
Phone # _____
Address _____

Weight History: Please indicate past weight gain/loss cycle(s).
(e.g. Gained 15 lbs. over 5 years. Lost 5 lbs. in past 2 months.)

Medical History: (e.g. kidney stones, high blood pressure, thyroid condition,
diabetes, heart disease etc.)

Indicate laboratory values if known:

Chol _____
MCV _____
HDL _____
LDL _____

Glucose _____
Triglyceride _____
Hemoglobin _____

Medications: List all medications that you currently take.

Have any members of your family had: (Check all that apply)

- | | | |
|--|---|--|
| <input type="checkbox"/> Obesity | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Cancer, type_____ | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> High Triglyceride | <input type="checkbox"/> Stroke | <input type="checkbox"/> Hypothyroid |

Do you have any food allergies or intolerances? Yes No

Specify: _____

Do you have concerns with:			If yes, explain?
Constipation	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Diarrhea	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Indigestion	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Heartburn	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Gas	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Appetite	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____

Do you take any vitamin, mineral, herbal, or food supplements? (e.g. Energy bars, protein drinks, protein bars, meal replacements)

Yes No

Type(s) / how often:

Do you consume caffeinated Beverages? (e.g. coffee, tea, energy drinks, Redbull, sports supplement, soda)

Yes No

Type(s) / how often:

Have you ever been advised by your doctor to follow any type of diet? (low salt, low fat, no sugar, etc.)

What changes did you make at that time?

Who usually does the grocery shopping?

What do you look for on nutrition labels?

Diet History

The following questions are about your typical eating pattern:

How many days per week do you eat (Breakfast) _____ (Lunch) _____
(Dinner) _____

How often do you snack? () Once daily () Twice daily () Three times
daily () More than three times daily

When do you usually snack?

What is a typical snack you choose?

Do you eat out? () Yes () No How often per week?

Which restaurant (s) do you usually choose?

Do you drink beer, wine, or mixed drinks (beverages containing alcohol)?

() Yes () No

If yes, indicate type of alcohol containing beverage you drink.

Number of beverages per week: _____

Do you smoke?

() Yes () No

Do you eat when you feel: (circle all that apply)

Happy Lonely

Sad Bored

Stressed Anxious Other: _____

What foods do you typically eat when you feel this way? _____

Do you have a concern with:

Binging () Yes () No

Purging () Yes () No

Compulsive Eating () Yes () No

Night time snacking () Yes () No

Social eating (parties etc.) () Yes () No

Where / how do you eat the following meals on a typical day: (Circle all that apply)

Breakfast: At the kitchen table
Watching TV
In the car
Standing up
At work
Restaurant/ fast food
Do not eat breakfast

Lunch: At the kitchen table
Watching TV
In the car
Standing up
At work
Restaurant/ fast food
Do not eat lunch

Dinner: At the kitchen table
Watching TV
In the car
Standing up
At work
Restaurant/ fast food
Do not eat dinner

Snacks: At the kitchen table
Watching TV
In the car
Standing up
At work
Do not eat snacks

Do you eat with others? Yes No

Do you cook? Yes No

Who usually prepares the food at home?

What activities / hobbies do you have?

Are you active in day to day life?

Yes

No

Specify:

Do you exercise?

Yes

No

If yes, how many days per week do you exercise?

Type and duration of exercise

What are your favorite foods?

What foods do you dislike?

What would you like to change about your eating habits?

FOOD FREQUENCY QUESTIONNAIRE

How often do you eat the following foods **per week**?

Food	Times Per Week	Food	Times Per Week	Food	Times Per Week
Eggs		Bread		Sweets	
Cheese		Nuts		Ice Cream	
Milk (Specify)		Rice/Pasta		Water	
Yogurt		Beans		Coffee/Tea	
Cottage Cheese		Bacon/Sausage		Carbonated Beverages	
Pizza		Potatoes		Energy Drinks	
Red Meat		Sweet Potatoes		Alcohol	
Chicken/Turkey		Frozen Dinners		Fruit Juice	
Fish		Fried Foods		Vegetables	
Soy Products		Restaurants		Corn, Peas, Lima Beans	
Luncheon Meat		Fast Food/Take out		Dietary Supplements	
Hotdogs		Salty Snacks		Ethnic Foods (Explain)	
Oatmeal/ oat bran		Margarine/Butter		Other:	

24-Hour Recall

Please indicate what you eat and drink on a "typical day."

	Time of Day	Food eaten (Please describe and include quantity of each item)
Breakfast		
Lunch		
Dinner		
Snacks		