

**New Client Questionnaire and Three-Day Record**

Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Email \_\_\_\_\_ Occupation \_\_\_\_\_

Marital Status \_\_\_ M \_\_\_ D \_\_\_ W \_\_\_ S \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Age \_\_\_\_\_ Sex: \_\_\_\_\_

Desired Weight \_\_\_\_\_ Last time you weighed desired weight \_\_\_\_\_

Have you tried to lose weight before? ( ) Yes ( ) No If Yes, when? \_\_\_\_\_

Diet (specify) \_\_\_\_\_ Weight Change \_\_\_\_\_ How long did it last? \_\_\_\_\_

**Weight History:**

Childhood	___ Underweight	___ Normal	___ Overweight	___ Obese
Teenage	___ Underweight	___ Normal	___ Overweight	___ Obese
20's	___ Underweight	___ Normal	___ Overweight	___ Obese
30's	___ Underweight	___ Normal	___ Overweight	___ Obese
40's	___ Underweight	___ Normal	___ Overweight	___ Obese
50's	___ Underweight	___ Normal	___ Overweight	___ Obese
60's +	___ Underweight	___ Normal	___ Overweight	___ Obese

**Family Weight History:**

Mother	___ Underweight	___ Normal	___ Overweight	___ Obese
Father	___ Underweight	___ Normal	___ Overweight	___ Obese
Sibling 1	___ Underweight	___ Normal	___ Overweight	___ Obese
Sibling 2	___ Underweight	___ Normal	___ Overweight	___ Obese

Elimination Habits \_\_\_ More than 1 time per Day \_\_\_ Daily \_\_\_ Less than Daily

Have you ever used laxatives for weight control? ( ) Yes ( ) No

Have you ever purged for weight control? ( ) Yes ( ) No

Do you have any food allergies/Intolerances? ( ) Yes ( ) No

If Yes, Specify: \_\_\_\_\_

# Nutrition Moves!

**Geri Lynn Grossan, RD, MEd, CDE**

Medical History: (list chronic illnesses, surgeries, major hospitalizations)\_\_\_\_\_

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Current Medications: \_\_\_\_\_

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Do you take any vitamin, mineral or food supplements? ( ) Yes ( ) No

If Yes, List \_\_\_\_\_

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Have you been advised by your physician to follow a type of diet? ( ) Yes ( ) No

If Yes, Type of Diet: \_\_\_ No Salt \_\_\_ Low Cholesterol \_\_\_ No Sugar \_\_\_\_\_ Other

Blood Work Values: (provide copies of recent blood work if available)

\_\_\_ Glucose \_\_\_ HgbA1C \_\_\_ Cholesterol \_\_\_ HDL \_\_\_ LDL \_\_\_ Triglycerides

Other pertinent values \_\_\_\_\_

Are your menstrual periods regular? ( ) Yes ( ) No ( ) NA

Do you exercise? ( ) Yes ( ) No

If Yes, Type/duration \_\_\_\_\_

Describe what you do to relax \_\_\_\_\_

**\*\*\*\*\* The following are questions about your typical eating patterns \*\*\*\*\***

How many days per week do you eat? (Breakfast)\_\_\_\_\_ (Lunch)\_\_\_\_\_ (Dinner)\_\_\_\_\_

How often do you snack? ( ) once daily ( ) twice daily ( ) three or more times daily

When do you usually snack? ( ) mid-morning ( ) mid-day ( ) after dinner

Do you eat out? ( ) Yes ( ) No If Yes, How often? \_\_\_\_\_

Type of restaurants? \_\_\_\_\_

# Nutrition Moves!

**Gerri Lynn Grossan, RD, MEd, CDE**

Do you drink alcohol? ( ) Yes ( ) No # of drinks/week \_\_\_\_\_

Do you eat standing up? ( ) Yes ( ) No ( ) Occasionally

Do you eat at a table? ( ) Yes ( ) No ( ) Occasionally

Do you eat alone? ( ) Yes ( ) No ( ) Occasionally

Do you eat in the car? ( ) Yes ( ) No ( ) Occasionally

Do you feel you eat fast? ( ) Yes ( ) No ( ) Occasionally

Do you think you are an emotional eater? ( ) Yes ( ) No ( ) Occasionally

Do you engage in other activities when you eat? ( ) Yes ( ) No  
If Yes, what activities? \_\_\_\_\_

Are you responsible for grocery shopping ( ) Yes ( ) No  
If No, Who usually does the grocery shopping? \_\_\_\_\_

Do you read labels? ( ) Yes ( ) No  
If Yes, What do you look for on labels? \_\_\_\_\_

Do you prepare the food you eat? ( ) Yes ( ) No  
If No, Who usually prepares the food at home? \_\_\_\_\_

Is there any member of your household on a special diet? ( ) Yes ( ) No  
If Yes, What special diet? \_\_\_\_\_

What are your favorite foods? \_\_\_\_\_  
\_\_\_\_\_

Would you like to change your eating habits? ( ) Yes ( ) No  
If yes, Please explain why? \_\_\_\_\_  
\_\_\_\_\_

What are your goals for the initial nutrition consultation? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

# Nutrition Moves!

**Geri Lynn Grossan, RD, MEd, CDE**

## Food Frequency Check List

	Never	Less than 1 time per week	2-3 times per week	4-6 times per week	More than once a day
Lean beef					
High fat beef					
Sausage, bacon					
Lunchmeat-turkey, chicken					
Lunchmeat - bologna, salami					
Pork					
Poultry					
Poultry-prebreaded (nuggets)					
Poultry-fried					
Fish					
Fish-prebreaded (nuggets)					
Fish -fried					
Shellfish					
Beans, lentils, legumes					
Peanut butter					
Pizza					
Milk (type)					
Cream					
Cheese					
Cheese-Regular					
Cheese-Low Fat					
Cheese Non-fat					
Yogurt					
Ice cream					
Frozen Yogurt					
Eggs					
Oils					
Butter					
Margarine					
Vegetables					
Salads					
Fruits					

# Nutrition Moves!

Gerl Lynn Grossan, RD, MEd, CDE

	Never	Less than one time per week	2-3 times per week	4-6 times per week	More Than Once A Day
Fruit Juice					
Breads					
Cereals					
Pasta, noodles, rice					
Potatoes					
Commercial baked goods (cakes, pies, pastries, muffins)					
Cookies-Regular					
Cookies- Low Fat					
Cookies-Fat Free					
Soft drinks-Regular					
Soft drinks-Diet					
Snack crackers					
Nuts and Seeds					
Potato chips or Corn chips					
Sherbets and Ices					
Candy					
Frozen Meals					
Chinese food					
Fast food					
Substitute foods (Soy products, Boca burgers)					
List other foods you eat not mentioned:					

Please Follow Instructions Carefully In Completing This  
Three-Day Record

1. Write down everything you eat and drink and all vitamin and mineral supplements taken for three (3) days.
2. Measure and record the amount of food served in portion sizes of level measuring cups, teaspoons, tablespoons, ounces. Include slices or inches. You may use a food scale if you have one.
3. Indicate how the food was prepared such as fried, steamed, baked, raw, etc.
4. List brand names of all food products, for example oatmeal might be “Quick Quaker Oats”
5. Be sure to measure and record all those little extras....gravies, salad dressings, taco sauce, pickles, jelly, sugar, ketchup, margarine etc. Indicate the amounts.
6. Try to include at least one weekend day if possible.
7. Describe how you are feeling in the emotional awareness and physical awareness columns. For example, bored and tired, happy and energetic, sad and lethargic, lonely and achy.

# Nutrition Moves!

Gerri Lynn Grossan, RD, MEd, CDE

Date \_\_\_\_\_

Amount	Meal	Time	Emotional Awareness	Physical Awareness
	<b>Breakfast</b>			
	<b>Snack</b>			
	<b>Lunch</b>			
	<b>Snack</b>			
	<b>Dinner</b>			
	<b>Snack</b>			

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