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NUTRITION HEALTH ASSESSMENT

NAME (First, Last, Middle)

ADDRESS (Street, City, State, Zip code)

TELEPHONE

Home (_____) _____

Work (_____) _____

Cell (_____) _____

EMAIL _____

INSURANCE PROVIDER: _____

Primary Insurance Holder: _____ Relationship: _____

Group # _____

Member ID# _____

SEX : M _____ F _____

HEIGHT _____ **CURRENT WEIGHT** _____

AGE _____ **DATE OF BIRTH** _____

ETHNIC BACKGROUND

1. ___ White, not of Hispanic background
2. ___ Black, not of Hispanic Background
3. ___ Hispanic
4. ___ American Indian/Alaskan native
5. ___ Asian
6. ___ Pacific Islander

MARITAL STATUS

1. ___ Single
2. ___ Married
3. ___ Widowed
4. ___ Divorced/Separated

I. DIET HISTORY

Usual Weight _____

Have you lost or gained any weight over the past year? YES _____ NO _____
If yes, please explain.

Do you have any food allergies or intolerances? YES _____ NO _____
If yes, please list.

Are you currently on a special diet? YES _____ NO _____
If yes, explain.

Have you followed any diets in the past? If so, please describe:

How many times per week do you eat at restaurants or consume take-out or fast food?

MEDICAL HISTORY

Have you or a blood-related family member ever been diagnosed with the following conditions?

Self / Family

- Cardiac arrhythmia
- Elevated cholesterol
- Diabetes Type I
- Diabetes Type II
- Kidney Disease
- Eating Disorder (specify)

Self / Family

- Asthma
- Stroke
- Depression
- Heart disease
- High blood pressure
- Cancer (specify type)

Self / Family

- Hypothyroid
- Hyperthyroid
- Alcoholism
- Arthritis
- Overweight/obesity
- Other (explain)

In addition, please check all that apply to you.

Depression _____ PCOS _____
Diverticulosis _____ Vomiting _____
Chronic constipation _____ Acid Reflux/GERD _____
Anemia _____ Ulcers _____
Nausea _____ Chronic fatigue _____
Diarrhea _____ Smoker _____
IBS _____

Do you take vitamins/minerals or herbal supplements? YES ____ NO ____
If yes, please list.

List any medications you are currently taking.

Are you pregnant? Yes ____ No ____
If yes, how many weeks? _____

Are you breastfeeding? Yes ____ No ____

ACTIVITY

Please complete the chart with activities you may do in your free time or practice regularly.

| Activity and Intensity* | Length of Time (in minutes) | Times Per Week | Times Per Month |
|-------------------------|-----------------------------|----------------|-----------------|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

* Low = if you are moving but heart rate and breathing remain the same

Moderate = if your breathing and heart rate increase

High = if you are unable to carry on a conversation during the activity

Please record an average day's food intake and meal/snack times.

Breakfast / time:

Snack / time:

Lunch / time:

Snack / time:

Dinner / time:

Snack / time:

Please describe what you believe are your eating issues. (e.g. Do you have problems with portion control? Do you binge eat? Are you a stress eater?)

Please list any concerns or information you would like to discuss that have not been addressed above.

**If available, please bring a copy of recent lab work to your first office visit.