Liat Golan RD,LD/N
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DIETARY ANALYSIS FORM

Name ______________________________ Date__________
Phone ____________________ ____________________
Cell Home
Address____
Email Address ___________________________________
Date of Birth_________________ Male_______ Female______

I. Health Background

	YOU yes	YOU no	FAMILY yes	FAMILY no
Heart related condition	___	___	___	___
High cholesterol	___	___	___	___
Hypertension	___	___	___	___
Cancer	___	___	___	___
Constipation	___	___	___	___
Diabetes	___	___	___	___
Gastrointestinal disease	___	___	___	___
Allergies	___	___	___	___
Food intolerance	___	___	___	___
Eating Disorders	___	___	___	___
Do you smoke?	___	___	___	___
Other	___	___	___	___

If you answered yes to any of the above, please explain:
____
____
____

Do you take vitamins, minerals and/or other supplements?___yes ___no
If yes, please list:_________________________________
____
____

II. Weight History: Height_____Weight_____ Desired Weight_____

Does your weight fluctuate? ___yes ___no If yes, please explain
____
____

Which diets have you followed during the past 3 years?_______________

III. Exercise Pattern
Do you follow a regular exercise program? ___yes ___no
If yes, describe your program and the frequency and duration.
If no, please describe why you are currently abstaining from exercise.

____
____

IV. Lifestyle Information
Do you prepare meals at home? ___yes ___no
If no, who does? ____

How often do you eat out of your home or order food from outside?
____

Do you travel frequently? ___yes ___no If yes, please explain:
____
____

Do you follow a special diet? If yes, briefly describe:
____
____

V. What are your reasons for scheduling a nutrition consultation?
____
____

VI. Are you under a physician's care for a nutrition or diet related problem? ___yes ___no If yes, please give name and address of your doctor.
____
____

VII. Please add any pertinent information which you feel will help me to accurately assess your background.
____
____
____
____
____

Health Profile

NAME ______________________ DATE __________ WEEK ______________

Rate each of the following symptoms based upon your typical health profile for: ☐ *Past 30 days* ☐ *Past 48 hours*

Point Scale	
0	*Never* or *almost never* have the symptom
1	*Occasionally* have it, effect is *not severe*
2	*Ocasionally* have it, effect is *severe*
3	*Frequently* have it, effect is *not severe*
4	*Frequently* have it, effect is *severe*

HEAD

______ Headaches
______ Faintness
______ Dizziness
______ Insomnia
______ TOTAL

EYES

______ Watery or itchy eyes
______ Swollen, reddened or sticky eyelids
______ Bags or dark circles under eyes
______ Blurred or tunnel vision (does not include near- or far-sightedness)
______ TOTAL

EARS

______ Itchy ears
______ Earaches, ear infections
______ Drainage from ear
______ Ringing in ears, hearing loss
______ TOTAL

NOSE

______ Stuffy nose
______ Sinus problems
______ Hay fever
______ Sneezing attacks
______ Excessive mucus formation
______ TOTAL

MOUTH/ THROAT

______ Chronic coughing
______ Gagging, frequent need to clear throat
______ Sore throat, hoarseness, loss of voice
______ Swollen or discolored tongue, gums or lips
______ Canker sores
______ TOTAL

SKIN

______ Acne
______ Hives, rashes, dry skin
______ Hair loss
______ Flushing, hot flashes
______ Excessive sweating
______ TOTAL

HEART

______ Irregular or skipped heartbeat
______ Rapid or pounding heartbeat
______ Chest pain
______ TOTAL

LUNGS

______ Chest congestion
______ Asthma, bronchitis
______ Shortness of breath
______ Difficulty breathing
______ TOTAL

DIGESTIVE TRACT

______ Nausea, vomiting
______ Diarrhea
______ Constipation
______ Bloated feeling
______ Belching, passing gas
______ Heartburn
______ Intestinal/stomach pain
______ TOTAL

JOINTS / MUSCLE

______ Pain or aches in joints
______ Arthritis
______ Stiffness or limitation of movement
______ Pain or aches in muscles
______ Feeling of weakness or tiredness
______ TOTAL

WEIGHT

______ Binge eating/drinking
______ Craving certain foods
______ Excessive weight
______ Compulsive eating
______ Water retention
______ Underweight
______ TOTAL

ENERGY / ACTIVITY

______ Fatigue, sluggishness
______ Apathy, lethargy
______ Hyperactivity
______ Restlessness
______ TOTAL

MIND

______ Poor memory
______ Confusion, poor comprehension
______ Poor concentration
______ Poor physical coordination
______ Difficulty in making decisions
______ Stuttering or stammering
______ Slurred speech
______ Learning disabilities
______ TOTAL

EMOTIONS

______ Mood swings
______ Anxiety, fear, nervousness
______ Anger, irritability, aggressiveness
______ Depression
______ TOTAL

OTHER

______ Frequent illness
______ Frequent or urgent urination
______ Genital itch or discharge
______ TOTAL

GRAND TOTAL ______________

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New Patient Introduction Form

Please print clearly:
Patient Name: ____Date:_________

Referred By:____

1. **Chief Concerns:**

2. Dietary Intake for 3 days before appointment (use separate sheet if needed)

Breakfast:	Breakfast:	Breakfast:
Snack:	Snack:	Snack:
Lunch:	Lunch:	Lunch:
Snack:	Snack:	Snack:
Dinner:	Dinner:	Dinner:
Snack:	Snack:	Snack: