Name_____ Date_____

Best Contact Phone Number_____ E-mail_____

Agreement of Participation and Confidentiality

Your signature below indicates your permission and willingness to participate in the below assessments, questionnaires and interviews and *consider* the potential program or recommendations, including interviews, counseling, medical nutrition therapy, personal training sessions and subsequent dietary/nutrition/exercise/health recommendations. All information and data discussed, written, typed, or communicated will be strictly confidential between the patient and the Odom Health & Wellness healthcare team.

You agree that the information you provide in the forms, assessments and interviews is accurate and current to the best of your ability. The OHW team commits to helping you reach your goals; encouraging and motivating you to overcome obstacles; equipping you to make healthy decisions and not giving up on you or your goals.

You also acknowledge that OHW is not solely responsible for your complete healthcare and needs to understand and be made aware of any changes or concerns in your health.

Signature: _____ Date: _____

Nutrition Assessment

What is the main reason or purpose for which you are seeing the registered dietitian nutritionist?

_____

Section1: Demographic Data

Today's Date: _____ Sex: M F Age:_____ Date of Birth: _____ Height:_____ ____Current Weight:_____
Usual Weight: _____ Weight 6 Months Ago:_____

Section 2: Health History

1. List any medical conditions or diagnoses you have been treated for with prescriptions, surgery, or other medical care in the last 5 years. _____

_____

_____

2. List any seasonal allergies and/or food allergies, sensitivities or intolerances. _____

_____

3. Please list all of the following taken currently or within the last year: medications, hormone replacement therapies, antibiotics or other medically related medications or remedies. (Vitamins, minerals, nutraceuticals, etc will be asked for in a different section.)

Name/Description	Dosage/Quantity	Frequency	Start Date	Stop Date
Example: Metformin	*500mg*	*2x/day*	*1/5/2015*	*Current*

5. Do you use tobacco in any way? ☐ Yes ☐ no How much? _____
Did you recently stop smoking? ☐ Yes ☐ no

6. Are you currently seeing any healthcare providers that you would like to include in your nutrition care and plans? _____

Section 4: Nutrition History

1. What change in your health or nutrition habits would you like to make? What nutrition concerns do you have? _____

_____

2. Do you follow a special dietary plan *prescribed for you, recommended by a medical provider or for religious reasons*? Examples include: low cholesterol, kosher or vegetarian? _____

3. Please list all vitamins, minerals, herbals, supplements, ergogenic aids, performance enhancers, protein powders, meal replacements or other nutraceuticals you are currently taking or have taken/used in the past year.

Name/Description	Dosage/Quantity	Frequency	Start Date	Stop Date
Example: One A Day Men's Multi Vitamin	*1200mg*	*Daily*	*1/5/2015*	*Current*

5. Are there certain foods that you do not eat ***ever***? _____
Why?_____

6. What beverages do you typically drink within a week and how much? _____

_____

8. How much water do you drink daily? _____

Nutrition Recall ***Please write out a list of your typical food and beverage intake.***

Time Food/Meal Description Amount Eaten

Section 5: Weight History ***(Please do not complete this section if this is not relevant to your visit.)***

1. Would you like to be weighed and/or measured today for a body composition assessment? ☐ Yes ☐ No
2. Have you had any recent changes in your weight, percent body fat or lean muscle mass you're concerned about? ☐ Yes ☐ No
If yes, please explain:_____

5. Have you tried to lose weight before? _____ How were you successful and how were you not successful?

_____

_____

Section 7: Activity and Exercise History

1. Do you enjoy physical activity/Exercise? ☐ Yes ☐ No Explain: _____

2. Please indicate all types of activity and duration you regularly participate in:

Activity	Type/Intensity (low-moderate-high)	Days per Week	Duration (Minutes)
Stretching/Yoga			
Cardio/Aerobics (Walk, jog, bike, swim, elliptical) List:			
Strength-training (Weight lifting, pilates, advanced yoga) List:			
Recreational Sports (Basketball, soccer, slow pitch)			
Elite Sports or Training (Marathon, triathlon, sports)			
Leisure (Lawn games, gardening, etc)			
Other (specify/describe)			

4. Do you currently have anyone assisting you or training you in your exercise? _____ Are you interested in a fitness assessment or customized training program? (*This is a complimentary offer to assist you in your nutrition-related goals.) _____

5. Do you eat or drink any pre-workout, pre-competition, post-workout or post-competition foods, meals, bars, supplements or beverages? _____ Please list and/or explain _____

_____

Section 9: Stress

1. Please rate your overall stress level. No Stress 1 2 3 4 5 A lot of Stress

2. Indicate *daily* stressors and rate the level of stress from 1 (extremely low) to 10 (extremely high):
Work_____ Family_____ Social_____ Financial_____ Health_____ Other_____

3. What helps you to unwind? _____

Section 10: Goals and Desired Outcomes

1. What would you like to accomplish by meeting with the dietitian? _____

_____

2. The nutrition/eating habits that are most challenging for me are: _____

_____

3. On a scale of 1 (not willing) to 5 (very willing), please indicate your readiness/willingness to do the following:

To improve your health, how willing/ready are you to…	1	2	3	4	5
Significantly modify your diet					
Take nutritional supplements each day					
Keep a Food Journal					
Modify your lifestyle (ex: work demands, sleep habits, physical activity)					
Practice relaxation techniques					
Engage in regular exercise/physical activity					
Have periodic lab tests to assess your progress					
Meet regularly with a dietitian					

4. Who could support and encourage you to make these changes? _____

Inflammation and Nutrition Related Symptoms Questionnaire

Rate each of the following symptoms based upon your typical health profile for the past 30 days. If you have been having recent or somewhat severe health symptoms, please indicate that you will fill out the questionnaire for the past 48 hours.

Point Scale:
0 = Never or almost never have the symptom
1 = Occasionally have it; effect is not severe
2 = Occasionally have it; effect is severe
3 = Frequently have it; effect is not severe
4 = Frequently have it; effect is severe

HEAD
____Headaches
____Lightheadedness
____Dizziness
____Insomnia
____Faintness
_____TOTAL

HEART
____Chest pain
____Irregular or skipped heartbeat
____Rapid or pounding heartbeat
_____TOTAL

EYES
____Bags or dark circles under eyes
____Watery or itchy eyes
____Swollen, reddened, or sticky eyelids
____Blurred or tunnel vision
_____TOTAL

EARS
____Itchy ears
____Ringing in ears/loss of hearing
____Earaches/ear infections
____Drainage from ear
_____TOTAL

NOSE
____Stuffy nose
____Sinus congestion, sinus infection
____Constant sneezing
____Hay fever/allergies
____Excess mucus formation
_____TOTAL

MOUTH/THROAT
____Chronic coughing
____Sore throat, hoarseness, loss of voice
____Gagging, frequent need to clear throat
____Swollen tongue, gums
____ Bleeding Gums
____Swollen lymph nodes
____Canker sores, mouth ulcers
_____TOTAL

LUNGS
____Asthma, bronchitis
____Chest congestion
____Shortness of breath
____Difficulty breathing
_____TOTAL

ENERGY LEVEL
____Fatigue/low energy
____ Tired but Wired
____Restlessness
____Hyperactivity
_____TOTAL

SKIN
____Acne
____Brown "age/liver spots"
____Hives, rashes, cysts, boils
____Dry skin
____Eczema or psoriasis
____Itchy skin/dermatitis
____Flushing, hot flashes
____Skin tags
____Body odor
____Excessive sweating
_____TOTAL

HAIR/NAILS
____Hair loss
____Brittle hair
____Thinning Hair
____Brittle nails
____White crescents on nails
____Cracking nails
____Ridges or bumps on nails
____Thin nails

JOINTS/MUSCLES
____Pain or aches in joints or lower back
____Tingling or numbness
____Stiffness or limitation of movement
____Arthritis
____Pain or aches in muscles
____Weakness
_____TOTAL

MENTAL/EMOTIONAL
____Poor memory
____Difficulty concentrating
____Mood swings
____Depression
____Anxiety
____Anger, irritability, or aggressiveness
____Insomnia
_____TOTAL

WEIGHT
____Underweight
____Overweight
____Difficulty losing weight
____Water retention
____Crave certain foods
_____TOTAL

DIGESTIVE TRACT
____Nausea, vomiting
____Diarrhea
____Constipation
____Bloated feeling
____Belching, passing gas
____Heartburn
____Intestinal/Abdominal Pain
_____TOTAL

OTHER
____PMS
____Frequent colds, flus
____Chemical or environmental sensitivities
____Food allergies/sensitivities
____Frequent or urgent urination
____Genital itch or discharge
_____TOTAL

GRAND TOTAL _____

15 or lower: low level of inflammation and nutrition influenced symptoms
16 to 49: moderate level of inflammation and nutrition influenced symptoms
50 or higher: high level of inflammation and nutrition influenced symptoms

Thank you for your willingness to share this information. I look forward to working with you to make lifestyle changes to meet your food and fitness objectives.