EAT SMART COACH

Patient Information **Please fill out the following information**

. **Date_____**

Name_____ Sex M F _____

Birthdate/&Age_____ /_____
Marital Status (circle one):Single, Married, Divorced, Widowed

Address_____City _____

State_____ Zip Code _____ E- Mail Address_____

Pt's contact name_____, Phone#_____

Occupation_____, Employer _____

Home Phone_____, Work Phone _____

Cell Phone_____, Best place to reach you_____

Current Height _____ Current Weight _____Lowest Weight & age_____

Highest weight & age _____ Weight you would like to achieve _____

Please list any medical conditions: Diabetes, Hypertension, and Cardiovascular problems, Operations, Hospitalizations etc.

Please list any medications you are currently taking _____

This there any family history of: Please circle
Heart Disease, Heart Attach, High Cholesterol, high Blood Sugar, Diabetes, Hypertension, High Blood pressure, Stroke, Cancer _____, Irritable Bowel Syndrome,

Psychiatric disorders, other _____
Do you have any problems with swallowing and or chewing? Yes, No

Do you have any problems with textures of food? _____
Do you have reflux or heart burn? Yes, No _____
Are you allergic to any foods? _____

Do you have any food restrictions? _____

Do you tolerate milk or dairy products? Yes No _____
Are you taking any vitamins, mineral, or herbal supplements? Please list amount and frequency_____
_____

Do you smoke? Yes, No # of cigarettes/ day _____
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Time of sleep _____Time you awake _____ # hrs of sleep you routinely get_____
Do you have trouble getting to sleep, or awake and have trouble getting back to sleep? Yes, No
Do you take anything to help you sleep? _____

Do you routinely encounter stress in your daily activities? Yes, No
How often _____? If there is a particularly bad time of day?
Describe _____

<u>Present Pattern of Intake:</u>

Do you drink coffee or tea and how many cups per day? _____
Regular, decaffeinated, herbal

Do you drink soft drinks, reg., or sugar free and if so how many per day? _____

Do you drink alcohol, wine, beer and or liquor? Amount per week _____
Other liquids you drink during the day, juice, water, sports drinks? _____

How often do you eat out per week? _____breakfast, lunch, dinner

Which type of restaurant do you frequent? Circle
Fast food, takeout food, salad bar, casual dining, formal restaurant,
Other_____

How many people are in the household? _____
Who does the supermarket shopping? _____Who does the cooking? _____
Do you use frozen prepared meals? Yes No How many per week? _____
What brands do you use? _____
Do you eat Breakfast? Yes No _____
How many meals a day do you eat? _____ How many times do you snack per day? _____Do you ever skip meals? Yes No If so when? _____

<u>Pattern of Eating: please check category</u>
Are you a Binge Eater? _____Night time eater? _____ eat in reaction to stress? _____

Eat in reaction to sadness, anger, and boredom? Other_____
Food Craving: Sweets _____, Soft drinks_____, Salt_____, Other_____
Have you ever had an eating disorder? Describe _____
<u>Activity Level:</u>
How often do you exercise? 5- 7 times per wk., 3-4 times per wk , 1-2 times, Never
What activities do you regularly do? Run, jog, walk, hike, bike, tennis, swim, lift weight, Work out, palates, yoga, exercise class, gardening, washing the car, and mowing the grass, house cleaning, and other_____
Are you physically active at work? Yes No
How vigorously are in you in your activity? Circle
Very strenuous, moderately strenuous, occasionally active, not active

Anything else you want to tell the Dietitian? _____

_____

24 hour recall:

Please record everything you ate and drank yesterday.
Use amounts or serving sizes, cups, ounces tsp etc. Include condiments, salad dressing, margarine, milk or sugar in coffee. Use back of page is necessary.

Date	Food	Amount	How prepared