

# Auburn University Medical Clinic

## Nutrition Services

### Contact Information

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Phone Number (Mobile/Work/Home): \_\_\_\_\_ Email: \_\_\_\_\_  
Address: \_\_\_\_\_ Preferred Method of Contact: \_\_\_\_\_

### Personal Information

Gender: Male Female Age: \_\_\_\_\_ Height: \_\_\_\_\_ Current Weight: \_\_\_\_\_

**Circle Client Status:** Student Faculty Staff

**Circle Reference:** Self Clinician Instructor Friend Other

Reason for clinical referral: \_\_\_\_\_

### Goals and Readiness To Change

Feel free to continue on to the back of this page or additional pages if necessary:

What is your **goal** for nutrition counseling? \_\_\_\_\_

\_\_\_\_\_

What are your **expectations** for nutrition counseling? \_\_\_\_\_

\_\_\_\_\_

What is your **driving force** for making changes regarding your health **right now**? \_\_\_\_\_

\_\_\_\_\_

What **changes** do you anticipate making? \_\_\_\_\_

\_\_\_\_\_

What **benefits** do you anticipate from such changes? \_\_\_\_\_

\_\_\_\_\_

How **motivated** are you to make changes? \_\_\_\_\_

\_\_\_\_\_

How **confident** are you in your ability to make changes? \_\_\_\_\_

\_\_\_\_\_

What do **others** currently think about your weight and how does this affect you? \_\_\_\_\_

\_\_\_\_\_

Other thoughts or concerns: \_\_\_\_\_

\_\_\_\_\_

**Behavior**

How much **fluid** do you **drink** each day? \_\_\_\_\_ oz What **type** of fluids do you **drink**? \_\_\_\_\_

How often do you eat **vegetables**?

Never 1-3 times weekly 4-5 times weekly 5-7 times weekly 1-3 times a day

What do you typically choose? What vegetables do you like? \_\_\_\_\_

How often do you eat **fruits**?

Never 1-3 times weekly 4-5 times weekly 5-7 times weekly 1-3 times a day

What do you typically choose? What fruits do you like? \_\_\_\_\_

How often do you eat **meat, fish, or poultry**?

Never 1-3 times weekly 4-5 times weekly 5-7 times weekly 1-3 times a day

What do you typically choose? What do you like most? \_\_\_\_\_

How often do you consume **milk, cheese, and yogurt**?

Never 1-3 times weekly 4-5 times weekly 5-7 times weekly 1-3 times a day

What would you typically choose? What do you like most? \_\_\_\_\_

How often do you eat **sugary or fried foods**?

Never 1-3 times weekly 4-5 times weekly 5-7 times weekly 1-3 times a day

How often do you consume **alcoholic beverages**? Please specify amount: \_\_\_\_\_

Never 1-3 times weekly 4-5 times weekly 5-7 times weekly 1-3 times a day

How often do you use **tobacco**? Please specify type and frequency: \_\_\_\_\_

Please describe your **physical activity** frequency, intensity and duration on a weekly basis: \_\_\_\_\_

**Circle Current Living Situation:**

Live alone partner/spouse partner/spouse & children roommates family other: \_\_\_\_\_

What are the eating habits of those closest to you? (family, friends, roommates): \_\_\_\_\_

Who is responsible for **meal planning and grocery shopping** in your living situation? \_\_\_\_\_

Do you have an AU **meal plan**? \_\_\_\_\_ On average, how long does it take you to **eat** a meal? \_\_\_\_\_

How many times a day do you eat (including snacks)? \_\_\_\_\_

How often do you eat out each week? \_\_\_\_\_

fast food places \_\_\_\_\_ other peoples' homes \_\_\_\_\_ restaurants \_\_\_\_\_ dining halls \_\_\_\_\_

## Health and Medical History

When was your last **consultation** with a physician? \_\_\_\_\_ Blood work/labs: \_\_\_\_\_

Do you take any **medications daily, including prescription or over-the-counter drugs**? Please describe in detail name/amount/dosage and duration of use:

Do you take **any vitamins or herbal supplements**? Please specify product and frequency:

Circle any that apply to **you or your immediate family members (siblings, parents, grandparents, parents' siblings)**:

Polycystic Ovarian Syndrome    Diabetes Mellitus Type I    Diabetes Mellitus Type II    Gout    Obesity  
Sleep apnea    Heart disease    Low or High blood pressure    Dyslipidemia: High LDL or Low HDL Cholesterol  
Auto-immune disorder    Thyroid Disorder    Metabolic disorder    Anxiety Disorders    Depression  
Osteoporosis/Osteopenia    Osteoarthritis    Disordered eating    Gastric bypass/lap band    Infertility  
Surgery in gastrointestinal or digestive system    Cancer- please list types: \_\_\_\_\_

Do you have any **personal concerns/problems** with the following:

Appetite    Bleeding gums    Bruising    Chewing or swallowing    Edema    Body Image  
Erectile dysfunction    Difficulty sleeping    Fatigue    Headaches    Bloating    Constipation  
Diarrhea    Hemorrhoids    Indigestion    Acid Reflux    Menstrual difficulties    Weight change  
Mood swings    Yeast infections    Urinary Tract Infections    Food Sensitivities/Allergies/Intolerances

## Weight and Diet History

Have you unintentionally lost or gained 10 or more pounds in the last 6 months? \_\_\_\_\_

Lowest (adult) weight: \_\_\_\_\_ Age: \_\_\_\_\_ Highest: \_\_\_\_\_ Age: \_\_\_\_\_

Your perception of healthy weight for you: \_\_\_\_\_ Age, if previously achieved: \_\_\_\_\_

Other details you wish to share regarding your weight history: \_\_\_\_\_

List any diets and/or weight loss programs you have tried:

Please indicate changes that you have made in the past regarding your health that you found to be helpful:

Please indicate changes that were not helpful or you did not feel successful with:

What do you consider to be a "good food?" And a "bad food?"

## Competency

On a scale of 1-10, answer the following five questions: 1= no skill/confidence, 5= satisfactory, 10= no room to improve!

How competent do you feel **grocery shopping**?

How competent do you feel **preparing and cooking food**?

How competent do you feel **measuring food and recording caloric intake**?

How competent do you feel when making decisions about **meal planning and food choices**?

How knowledgeable do you feel about **nutrition and your personal health**?

## Lifestyle

How do you **cope** with **stress**? What do you do to **manage** your stress?

Discuss your **support system**:

How do you measure **success**?

What is the most **difficult** time of day or most difficult lifestyle situation for you to make healthy choices?

Where do you get most of your **nutrition information**?

Have you ever taken a **nutrition class or course**? When and where?

Would you be interested in a **grocery store tour** with the dietitian? Yes or No

Are you willing to consider **food journaling**? Yes or No

Please circle your **topics of interest**:

Healthy Eating Habits	Weight Loss	Weight Gain	Vegetarian	Vegan
Sports Nutrition	Gastrointestinal Health	Disease Prevention	Eating Disorder	
Food Sensitivities/Allergies	Meal Planning	Cooking classes	Healthy Food Budget	
Dorm Room Cooking	Preconception/Prenatal	Other: _____		