Auburn University Medical Clinic:Campus Recreation Nutrition Services Satellite Office

Contact Information														
Name: Phone Number (Mobile/Work/Home): Address:				Date of Birth: Email: Preferred Method of Contact:										
							Personal Information							
							Gender: Male Femal	е	Age:		Height:			Current Weight:
Circle Client Status:	Student	t Faculty	/	Staff										
Circle Reference:	Self	Clinician	Instruct	or	Friend	Other								
Reason for clinical refer	ral:													
Goals and Readiness Feel free to continue on		•	or additic	onal pag	es if nec	essary:								
What is your goal for nu	utrition co	ounseling?												
What are your expecta t	tions for	nutrition counse	eling?											
What is your driving fo	rce for m	naking changes	regarding	your he	ealth righ	it now?								
What changes do you a	anticipate	e making?												
What benefits do you a	nticipate	from such char	iges?											
How motivated are you	ı to make													
How confident are you	in your a	ability to make c	hanges?											
What do others current	ly think a	about your weigh	nt and how	w does t	his affect	t you? _								
Other thoughts or conce	 erns:													

Please send in this form with your food journal at least 3 business days prior to your scheduled appointment.

Medical Clinic Main: (334) 844-4416 Medical Clinic Direct: (334) 844-2591 Campus Recreation: 334-844-0023

Behavior				
How much flui	d do you drink e	each day? oz	What type of fluids do you	drink?
How often do y	∕ou eat vegetab l	es?		
Never 1-3 tim	nes weekly	4-5 times weekly	5-7 times weekly	1-3 times a day
What do you ty	pically choose?	What vegetables do yo	ou like?	
How often do y	ou eat fruits ?			
Never 1-3 tim	nes weekly	4-5 times weekly	5-7 times weekly	1-3 times a day
What do you ty	pically choose?	What fruits do you like	?	
How often do y	ou eat meat, fis	h, or poultry?		
Never 1-3 tim	nes weekly	4-5 times weekly	5-7 times weekly	1-3 times a day
What do you ty	pically choose?	What do you like most	?	
How often do y	ou consume mi	lk, cheese, and yogur		
Never 1-3 tim	nes weekly	4-5 times weekly	5-7 times weekly	1-3 times a day
What would yo	u typically choos	se? What do you like m	ost?	
How often do y	ou eat sugary c	or fried foods?		
Never 1-3 tim	nes weekly	4-5 times weekly	5-7 times weekly	1-3 times a day
How often do y	ou consume alc	oholic beverages? Pl	ease specify amount:	
Never 1-3 tim	nes weekly	4-5 times weekly	5-7 times weekly	1-3 times a day
How often do y	ou use tobacco	? Please specify type	and frequency:	
Please describ	e your physical	activity frequency, int	ensity and duration on a w	eekly basis:
Circle Current	t Living Situation	on:		
Live alone	partner/spouse	e partner/spouse & d	children roommates	family other:
What are the e	ating habits of th	nose closest to you? (fa	amily, friends, roommates)	:
Who is respons	sible for meal pl	anning and grocery s	hopping in your living situ	ation?
Do you have a	n AU meal plan	?	On average, how long	does it take you to eat a meal?
How many time	es a day do you	eat (including snacks)?	?	
How often do v	ou eat out each	waak?		

2 Please send in this form with your food journal at least 3 business days prior to your scheduled appointment.

fast food places	food places other peoples' homes		restaurants	dining halls			
Health and Medical His	story						
When was your last con	nsultatation with a phy	sician?	Blood work/labs:				
Do you take any medica name/amount/dosage and	-	g prescript	tion or over-the-count	er drugs? Please desc	ribe in detail		
Do you take any vitami	ns or herbal supplem	ents? Plea	ase specify product and	frequency:			
Circle any that apply to	you or your immediat	e family m	nembers (siblings, par	ents, grandparents, pa	arents' siblings):		
Polycystic Ovarian Synd	drome Diabetes Me	llitus Type	I Diabetes Melli	tus Type II Gout	t Obesity		
Sleep apnea Heart	disease Low	or High blo	od pressure Dyslip	idemia: High LDL or Lov	w HDL Cholesterol		
Auto-immune disorder	Thyroid Disor	der	Metabolic disorder	Anxiety Disorders	Depression		
Osteoporosis/Osteopeni	Osteoporosis/Osteopenia Osteoarthritis		Disordered eating	Gastric bypass/lap ba	and Infertility		
Surgery in gastrointestin	nal or digestive system		Cancer- please list types:				
Do you have any perso	nal concerns/problen	ns with the	following:				
Appetite Bleedin	ng gums Bruis	ing	Chewing or swallowing	Edema	Body Image		
Erectile dysfunction	Difficulty sleeping	Fatigue	Headaches	Bloating	Constipation		
Diarrhea Hemorr	hoids Indig	estion	Acid Reflux	Menstrual difficulties	Weight change		
Mood swings Yeast infections Urinary Tract Infections Food Sensitivities/Allergie					ergies/Intolerances		
Weight and Diet Histor	ry						
Have you unintentionally	y lost or gained 10 or m	nore pound	s in the last 6 months?				
Lowest (adult) weight:	Age:	Highest:	Age:				
Your perception of healt	thy weight for you:		Age, i	previously achieved:			
Other details you wish to	o share regarding your	weight his	tory:				
List any diets and/or wei	ight loss programs you						
Please indicate changes	s that you have made i	n the past i	regarding your health th	at you found to be helpf	ful:		
Please indicate changes	s that were not helpful	or you did r	not feel successful with:				
What do you consider to	b be a "good food?" And	d a "bad fo	od?				

Competency On a scale of 1-10, answer How competent do you feel		: 1= no skill/confidence, 5	= satisfactory, 10= no room to improve!				
How competent do you feel	preparing and cooking fo	od?					
How competent do you feel	measuring food and reco	rding caloric intake?					
How competent do you feel when making decisions about meal planning and food choices?							
How knowledgeable do you	ı feel about nutrition and y	our personal health?					
Lifestyle							
How do you cope with stre	ss? What do you do to mar	age your stress?					
Discuss your support syst	em:						
How do you measure succ	ess?						
What is the most difficult to	me of day or most difficult li	festyle situation for you to	make healthy choices?				
Where do you get most of y	our nutrition information ?						
Have you ever taken a nut	rition class or course? Wh	en and where?					
Would you be interested in	a grocery store tour with t	he dietitian? Yes o	r No				
Are you willing to consider	food journaling? Yes o	or No					
Please circle your topics o	f interest:						
Healthy Eating Habits	Weight Loss	Weight Gain	Vegetarian Vega	an			
, ,	astrointestinal Health	Disease Prevention	Eating Disorder	u I			
Food Sensitivities/Allergies		Cooking classes	Healthy Food Budget				

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Preconception/Prenatal

Dorm Room Cooking

Other:____