COMPREHENSIVE
GASTROINTESTINAL HEALTH
EDUCATION. NUTRITION. COGNITION. PREVENTION.

NUTRITION THERAPY AND HISTORY

Name _____ **Date of Birth** _____

Have you ever met with a **dietitian** before? Yes ☐ No ☐

Have you changed your eating habits for a health reason? *(If yes, please describe)* Yes ☐ No ☐

Are you currently following a particular diet or nutrition plan? *(If yes, please describe)* Yes ☐ No ☐

_____

_____

Have you tried any specific diets in the past? Yes ☐ No ☐
(If yes, please list and describe what worked and why or why not.)

_____

_____

Do you have any **adverse food reactions** (intolerances or allergies)? *(If yes, please list, explain.)* Yes ☐ No ☐

_____

_____

Do you avoid any particular foods? *(If yes, please list and explain why.)* Yes ☐ No ☐

_____

_____

Do you have any of the following **symptoms upon eating**? Please check all that apply:

☐ Gas/bloating ☐ Diarrhea ☐ Constipation ☐ Pain and/or cramping

Does eating cause your symptoms to increase? If so, which ones?

_____

_____

Do you have or ever been diagnosed with an eating disorder? If so, please describe.

_____

_____

Please list any specific cultural dietary practices: _____

How many **meals** do you eat each day? _____ How many **snacks** do you eat each day? _____

Do you read food labels? Yes ☐ No ☐

How often do you eat **fast food** a week? _____

Do you use artificial sweeteners? If so, which ones? _____ Yes ☐ No ☐

Check all of the factors that apply to your **eating habits** and current lifestyle

- ☐ Loves to eat
- ☐ Loves to cook
- ☐ Emotional eater
- ☐ Late night snacker
- ☐ Doesn't know how to cook
- ☐ Family members differ in taste
- ☐ Dislikes cooking
- ☐ Fast eater
- ☐ Inconsistent eating patterns
- ☐ Dislikes healthy foods
- ☐ Rely heavily on convenience foods
- ☐ Eats fast food often
- ☐ Makes poor snack choices
- ☐ Confused about nutrition
- ☐ Live alone or eat alone often
- ☐ Meal plans
- ☐ Meal preps
- ☐ Time constraints to prep meals
- ☐ Travels frequently
- ☐ Uses food for comfort
- ☐ Skips meals

Provide an estimate of the amount of beverages you consume on average per day.

Water: _____ ounces or cups **Diet Soda:** _____ ounces or cups **Tea:** _____ ounces or cups

Coffee: _____ ounces or cups **Soda:** _____ ounces or cups **Alcohol:** _____ ounces or cups

WEIGHT HISTORY

Height: _____ **Current Weight:** _____ **Weight Range:** _____ **Desired Weight:** _____

Have you recently **lost or gained weight**? *Please describe.* Yes ☐ No ☐

LIFESTYLE INFORMATION

Do you engage in **physical activity** on a regular basis? *If yes, complete the table below.* Yes ☐ No ☐

ACTIVITY:	DAYS PER WEEK:	MINUTES PER SESSION:

On average, how many hours to do you **sleep per night**? ☐ Less than 6 ☐ 6-8 ☐ 8-10 ☐ More than 10

Check any that apply related to your **sleep patterns**: ☐ Trouble falling asleep ☐ Doesn't feel rested upon waking ☐ Wakes during the night ☐ Feels consistently rested

How do you **handle stress**?

What is your main **source of support**?

Please describe the **health and/or nutrition concerns** would you like to focus on during your visit.

FOOD DIARY

Please record what you eat and drink in one typical day (24 hour period). Please be sure to include all beverages (including water), cream and sweetener added to beverages and condiments added to foods.

Start Time of Day: _____ **End Time of Day:** _____

TIME:	FOOD/DRINK ITEM:	AMOUNT:	LOCATION:	GI SYMPTOMS?