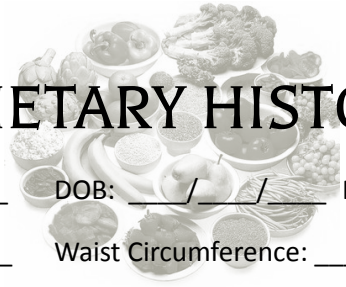

DIETARY HISTORY

Name: _____ DOB: ___/___/____ Race: _____ Date: _____

Wt.: _____ lbs. Ht: ___' ___" BMI: _____ Waist Circumference: _____ Abdominal Circ.: _____

BP: _____/_____ Hypertension? ____ Pulse: _____ Arrhythmia's? _____ CVD? _____ Kidney Dis.? _____

Diabetes? _____ Type I or Type II (Circle) Swollen Ankles? _____ Arthritis? _____

Medical Hx (Surgeries/Trauma's (MVA's, Fx's)/Concussions/Hospitalizations): _____

_____

_____

Family Hx (Diabetes/Heart Disease/Stroke/Cancer etc.): _____

_____

Nutrition Hx (Special diets/Supplements/Previous Care/Habits/Eating Disorders-Bulimia or Anorexia): _____

_____

_____

Do you think your issues with food are more genetic, psychological, chemical or social? And explain why? _____

_____

Usual Eating Patterns (include timing and location of meals & snacks): _____

_____

Food preferences: _____

_____

Allergies & Food Intolerances: _____

_____

Vitamins, Minerals & Supplement Use: _____

_____

Any changes in desire/craving for foods (Sugars, fats or salts) (satiety earlier or pain or discomfort)? _____

_____

Dental or oral problems (Chewing/Cavities/Dentures): _____

Bowel Habits (be descriptive-Gas/Bloating/Yeast/Stool frequency and soft or hard): _____

_____

Do you over eat or eat to the point where you feel physically ill? _____

Do you feel tired or fatigued after eating? _____

Do you find yourself constantly eating certain foods during the day? _____

Do you become agitated, have anxiety or other physical symptoms when you cut down on certain foods? _____

_____

Have you ever consumed certain foods to prevent those feelings of agitation or anxiety from developing? _____

_____

Pain during meals, after meals with any foods? _____

Amount of Water Usage/Day? _____ 8 oz. glasses/day (City/Tap/Well/Filtered/ Hydration Status): _____

Other Liquids? (Coffee, soda, sports drinks, tea, milk and how much?): _____