Welcome to On Nutrition! Please read the following before filling out this packet.

- Before your first visit, please complete this On Nutrition Questionnaire, which contains the following:

  - Medical/family history
  - Review of body systems
  - Lifestyle questionnaire
  - Food frequency questionnaire
  - 3 day food record
  - Privacy/HIPPA and financial agreement
  - Consent form

❖ Please attach a copy of any blood work you had done in the past 6 months.

❖ Please be sure this packet is returned **at least three days prior** to your consultation so that we have time to review it and research as needed. Send by:

  - Fax to: (585)385-1994 (Attention: On Nutrition)
  - Mail to: On Nutrition,10 Hagen Drive, Suite 200, Rochester, NY 14625

❖ Your first two consultations must be done in person, but if you would prefer to follow-up on Skype, provide your Skype name: _____. Skype may only be used for cash-pay clients.

❖ After your initial consultation, you must schedule at least one follow-up session, more may be needed to assess and/or add to your nutrition plan. You can schedule this appointment at the end of your first consultation.

We look forward to working with you on your goal toward health and wellbeing.

Carol Plotkin, MS, RDN, CDN, ACSM
Lisa Fischer, RD, CDN
www.rochesternutrition.com

ONNUTRITION Questionnaire Appointment Date:

Name: _____ Age: _____ Date of birth: _____

Phone (Home): _____ (Cell):_____ (Work):_____

Email: _____

Primary address: _____

City, State, Zip code: _____

Primary physician: _____ Phone: _____

Other pertinent provider: _____ Phone: _____

Other pertinent provider: _____ Phone: _____

Health History
Height: _____ Weight: _____ Weight 6 months ago: _____ 1 year ago: _____ Highest adult weight: _____ Desired weight: _____
Medical History/Surgeries (e.g. heart disease, asthma, IBS, smoker, tonsillectomy) _____ _____ _____ _____ _____
Family History
Family member: _____ *Medical condition*: _____
Family member: _____ *Medical condition*: _____
Family member: _____ *Medical condition*: _____
Family member: _____ *Medical condition*: _____
Comments:

Health History
What is your reason for seeking nutrition counseling? _____ _____

Past and Current Medications (over the counter or prescription)

Name	Dose	Frequency	Length of Use	Reason for Taking

Are you sensitive to low levels of medication and/or caffeine?

Do you have a history of antibiotic use?

Dietary or Herbal Supplements

Name/Brand	Dose	Frequency	Length of Use	Reason for Taking

Have you noticed a difference in your health since starting these supplements? Explain.

Physical Activity Frequency

	Monthly	Weekly	Daily	Multiple times daily	Duration of exercise
Active lifestyle					
Cardio exercise					
Strength building					
Stretching, yoga					

Has your doctor told you not to participate in certain physical activities? If yes, please explain.

Metabolic Profile

Office Use Only

M=10(____ kg) + 6.25(____ cm) – 5(____ years) + 5
F=10(____ kg) + 6.25(____ cm) – 5(____ years) - 161

_____ * _____ = _____
Measured Resting Energy Expenditure Activity Factor Total Calories

_____
Calories to maintain / lose / gain weight

Personal Meal Plan Daily Totals

_____ Starch _____ g Carbohydrate _____ %
_____ Vegetable
_____ Fruit _____ g Protein _____ %
_____ Milk
_____ Meat (Protein) _____ g Fat _____ %
_____ Fat

Review of Body Systems

Please place an **"X"** next to anything you are currently experiencing. Issues that you had previously, but no longer have, mark with a **"P."** Also provide answers to those items marked with a question mark.

Head

- [ ] seizure
- [ ] headache
- [ ] migraines

Eyes/Ears/Nose

- [ ] vision loss
- [ ] eye discharge
- [ ] eye redness
- [ ] ear/eye infection
- [ ] corrective lenses
- [ ] hearing loss
- [ ] ringing the ears
- [ ] ear discharge/itching
- [ ] pain
- [ ] nosebleed
- [ ] nasal congestion

Neck and Throat

- [ ] pain
- [ ] lump
- [ ] enlarged thyroid
- [ ] stiffness
- [ ] tonsillitis

Male Reproductive

- [ ] difficulty with urination
- [ ] Benign Prostatic Hypertrophy
- [ ] pain / swelling in testicles or prostate
- [ ] vasectomy
- [ ] erectile insufficiency
- [ ] low sperm count
- [ ] poor sperm motility

Lymph Nodes

- [ ] congestion
- [ ] swollen
- [ ] painful

Neuropsychiatric

- [ ] phobias
- [ ] insomnia
- [ ] depression
- [ ] anxiety
- [ ] attention deficit
- [ ] mental sluggishness
- [ ] other mental disorder
- [ ] abnormal physical movements

Female Reproductive

Breasts

- [ ] tenderness
- [ ] abnormalities, lumps
- [ ] discharge
- [ ] perform breast self-exams?

Genitals

- [ ] vaginal discharge
- [ ] yeast infections
- [ ] pelvic pain or masses
- [ ] abnormal pap, resulting action?

Menses

Date of last menses

Length of menses days

- [ ] painful cramps
- [ ] bleeding between cycles
- [ ] not menstruating
- [ ] fibroids
- [ ] endometriosis
- [ ] PCOS

Menopausal women

- [ ] menopausal symptoms
- [ ] vaginal dryness
- [ ] hormone replacement therapy
- [ ] osteoporosis

Male and Female

Sexually transmitted disease?

Birth control, what form? [ ]

- [ ] low libido
- [ ] painful intercourse /orgasm

Urinary

Urinations a day?

Color of urine?

- [ ] urinary tract infection
- [ ] kidney infection
- [ ] kidney stones
- [ ] swelling
- [ ] incontinence
- [ ] urgency
- [ ] frequency
- [ ] pain on urination
- [ ] blood in urine
- [ ] dark circles under eyes

Gastrointestinal

- [ ] bad breath
- [ ] ulcers
- [ ] bloating/gas
- [ ] pain/cramping
- [ ] nausea
- [ ] acid reflux/GERD
- [ ] constipation
- [ ] variable bowel habits
- [ ] diarrhea
- [ ] undigested food in stools
- [ ] blood in stools
- [ ] hemorrhoids
- [ ] liver/gallbladder issues

Bowel movements

per day? OR # per week?

Quality?

- [ ] pebbly
- [ ] fully formed
- [ ] soft & largely unformed
- [ ] loose and unformed

Respiratory

- [ ] congestion
- [ ] sinus pain/inflammation
- [ ] difficulty breathing
- [ ] cough
- [ ] asthma
- [ ] tuberculosis

Allergic & Immunologic

- [ ] respiratory allergies
- [ ] immune disorder
- [ ] frequent colds or flu
- [ ] food allergies
- [ ] food sensitivities

Cardiovascular

- [ ] heart attack
- [ ] low blood pressure
- [ ] high blood pressure
- [ ] heart palpitations
- [ ] chest pain
- [ ] high cholesterol
- [ ] varicose/spider veins
- [ ] cold hands and feet
- [ ] stroke
- [ ] clotting disorder
- [ ] bruise easily

Endocrine

- [ ] low energy level
- [ ] hypothyroid (low)
- [ ] hyperthyroid (high)
- [ ] low blood sugar
- [ ] diabetes

Skin

- [ ] rash
- [ ] dry skin
- [ ] itching
- [ ] acne
- [ ] rosacea
- [ ] bruise easily
- [ ] nail problems
- [ ] hair quality changes
- [ ] slow wound healing

Musculoskeletal

- [ ] muscle pain
- [ ] arthritis / joint pain
- [ ] stiffness
- [ ] gout
- [ ] back ache/pain
- [ ] mobility restrictions

Occupation and Interests	
Occupation:	How long?
Satisfaction (1-10):	
Interests/hobbies:	

Stress
On a scale from 1 (not stressful) to 10 (extremely stressful), how stressful is: Work: _____ Health status: _____ Family/social life: _____ Life in general: _____
Do you feel your health is largely ____ in your control or ____ outside your control?
When was the last time you felt *well*, physically and/or emotionally?
Did something trigger your change in health or emotional well-being?
Do you feel your life has purpose?
Do you believe stress is reducing the quality of your life?

Sleep
What time are you typically in bed?
What time do you fall asleep?
Typical number of hours you sleep:
of times you awaken during the night:
Reason(s) you wake at night:
Do you feel rested upon waking?

Nutrition Assessment
Have you made any recent changes to your eating habits? *If yes, please explain*:
Do you avoid any particular foods? *If yes, please specify food and reason*:
Do you have (or have you had) an eating disorder? *If yes, please explain*:
Do you have any adverse food reactions (allergies/intolerances)? *If yes, please explain*:
Do you drink alcohol? *If yes, how many ounces per day, week, or month?*
Do you drink coffee or other caffeinated beverages? *If yes, how many ounces per day or week?* What do you put in your coffee?
Do you use artificial sweeteners? *If yes, which ones?*
Circle all that apply to your current lifestyle and eating habits: Fast eater Erratic eating patterns Overeater Late night eater Convenience eater Love to eat Poor snack choices Love to cook Often eat alone Time constraints Emotional eater Fast food eater Do not plan meals/menus Travel frequently Eat because I have to Eat when bored Negative relationship with food Dislike healthy food Confused about nutrition

Food/Drink	Frequency				Comments
	Monthly	Weekly	Daily	Multiple times a day	
Caffeine					In what form?
Soda/Soft Drinks					What type(s)?
Alcohol					What type(s)?
Herb tea					What type(s)?
Red Meat					Beef, ☐ Lamb, ☐ Sausage/deli ☐
White Meat					Poultry, ☐ Pork ☐ Sausage/deli ☐
Eggs					
Fish/Shellfish					
Nuts & Seeds					
Fruits					Canned, ☐ Fresh, ☐ Frozen ☐
Vegetables					Canned, ☐ Fresh, ☐ Frozen ☐
Lentils & Beans					Canned, ☐ Fresh, ☐ Frozen ☐
Oils / fats (e.g., olive, butter)					What type(s)?
Dairy Products					Milk, ☐ Yogurt, ☐ Cheese, ☐ Butter ☐
Soy Products					What type(s)?
Whole grains					What type(s)?
Grain-based products					Bread, ☐ Pasta, ☐ Crackers ☐
"Junk / Fast Food"					What type(s)?
Fried Foods					What type(s)?

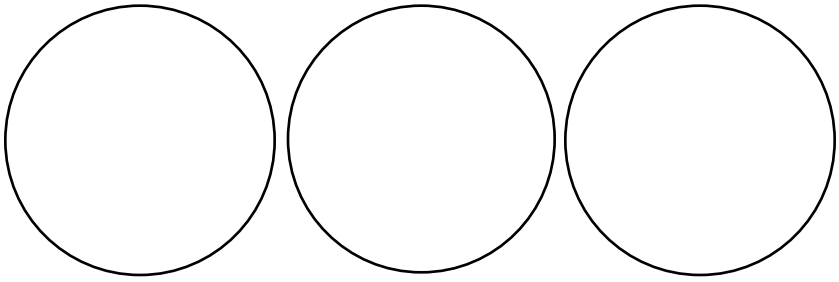
How many times each week do you eat each meal at home (vs. out)?	Breakfast, Lunch, Dinner
Approximately how many **ounces** of water do you drink per day?	oz Bottled, Filtered, Tap
Where do you grocery shop?	

Typical Bowel Habits (over last 4 months)
Do you have: __indigestion, __reflux, __gas or __feelings of fullness during or after meals? If after, how long after meals?
Does your stool have a strong odor? _____ Is there undigested food? _____
Does emotional stress or eating raw, fibrous foods cause cramps/pain?
Is your stool: ___ hard and dry, ___ formed/easy to pass, ___ loose, or ___ diarrhea?
Readiness Assessment
On a scale from 5 (very willing) to 1 (not willing), rate the following statements. "I will": Significantly modify my diet: 1__ 2__ 3__ 4__ 5__ Take nutritional supplements every day: 1__ 2__ 3__ 4__ 5__ Keep a record of everything I eat each day: 1__ 2__ 3__ 4__ 5__ Modify my lifestyle (work demands, sleep habits, etc): 1__ 2__ 3__ 4__ 5__ Practice a relaxation technique: 1__ 2__ 3__ 4__ 5__ Engage in regular physical activity: 1__ 2__ 3__ 4__ 5__ Have periodic lab tests to assess my progress: 1__ 2__ 3__ 4__ 5__ Follow a structured meal plan: 1__ 2__ 3__ 4__ 5__

3-Day Food Diary

Instructions:

- Record information as soon as possible after the food is consumed. Include all beverages (tea, coffee with sugar, alcohol, water, etc) in cups or ounces.
- Do *not* change your typical eating habits during the days you track your diet.
- Incorporate 2 week days and 1 weekend day.
- Record as much detail as possible including serving size that you ate, the brand name if applicable, and cooking methods.
- Use standard household measurements to specify serving size (1 cup, 1 tablespoon, etc)
- If you experience any adverse reaction during or after a meal, experience any significant hunger or stress level, please make a note of it.
- Please specify if you have skipped a meal and why.
- Make a note all bowel movements, their consistency (normal, loose, firm, etc) and time of movement.
- To the right, sketch **one day's worth** of how food looks on your breakfast, lunch, and dinner plates.



Day 1	Day 2	Day 3
Breakfast	Breakfast	Breakfast
Snack	Snack	Snack
Lunch	Lunch	Lunch
Snack	Snack	Snack
Dinner	Dinner	Dinner
Snack	Snack	Snack

Thank you for taking the time to fill out this questionnaire.