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Data Collection Form

Name: _____ Date: _____

Address: _____
_____

Phone: (day) _____ (evening) _____ (cell) _____
E-Mail: _____
Occupation:_____

Age: _____ Height: _____ (cm) _____ Weight: _____ (Kg) _____
BMI_____ Shaded areas are for office use.

Male/Female Weight loss goal: _____

M=66 + (13.7*___kg) + (5*___cm) - (6.8*years)
F=655 + (9.6*___kg) + (1.7*___cm) - (4.7*years)

_____ * _____ = _____
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

Nutrition Summary Sheet

Reason for nutrition
counseling_____
_____
_____
_____

Primary Care Physician Name _____
Phone #_____
Address_____
_____

Weight History: Please indicate past weight gain/loss cycle(s).
(e.g. Gained 15 lbs. over 5 years. Lost 5 lbs. in past 2 months.)

Medical History: (e.g. kidney stones, high blood pressure, thyroid condition, diabetes, heart disease etc.)

Indicate laboratory values if known:

Chol _____ Glucose_____
MCV_____ Triglyceride_____
HDL_____ Hemoglobin_____
LDL_____

Medications: List all medications that you currently take.

Have any members of your family had: (Check all that apply)

( ) Obesity ( ) Diabetes ( ) Heart Disease

( ) Cancer, type_____ ( ) High Cholesterol ( ) High Blood Pressure

( ) High Triglyceride ( ) Stroke ( ) Hypothyroid

Do you have any food allergies or intolerances? ( ) Yes ( ) No

Specify:_____

Do you have concerns with:		If yes, explain?
Constipation	( ) Yes ( ) No	_____
Diarrhea	( ) Yes ( ) No	_____
Indigestion	( ) Yes ( ) No	_____
Heartburn	( ) Yes ( ) No	_____
Gas	( ) Yes ( ) No	_____
Appetite	( ) Yes ( ) No	_____

Do you take any vitamin, mineral, herbal, or food supplements? (e.g. Energy bars, protein drinks, protein bars, meal replacements)

( ) Yes ( ) No

Type(s) / how often:

_____

_____

_____

Do you consume caffeinated Beverages? (e.g. coffee, tea, energy drinks, Redbull, sports supplement, soda)

( ) Yes ( ) No

Type(s) / how often:

_____

_____

Have you ever been advised by your doctor to follow any type of diet? (low salt, low fat, no sugar, etc.)

_____

_____

What changes did you make at that time?

_____

_____

Who usually does the grocery shopping?

_____

What do you look for on nutrition labels?

_____

_____

_____

Diet History

The following questions are about your typical eating pattern:

How many days per week do you eat (Breakfast) _____ (Lunch) _____ (Dinner) _____

How often do you snack? ( ) Once daily ( ) Twice daily ( ) Three times daily ( ) More than three times daily

When do you usually snack?

_____

What is a typical snack you choose?

_____

Do you eat out? ( ) Yes ( ) No How often per week?

_____

Which restaurant (s) do you usually choose?

_____

Do you drink beer, wine, or mixed drinks (beverages containing alcohol)?

( ) Yes ( ) No

If yes, indicate type of alcohol containing beverage you drink.
_____

Number of beverages per week: _____

Do you smoke? ( ) Yes ( ) No

Do you eat when you feel: (circle all that apply)
Happy Lonely
Sad Bored
Stressed Anxious Other:_____

What foods do you typically eat when you feel this way?_____
_____
_____
_____

Do you have a concern with:

Binging ( ) Yes ( ) No

Purging ( ) Yes ( ) No

Compulsive Eating ( ) Yes ( ) No

Night time snacking ( ) Yes ( ) No

Social eating (parties etc.) ( ) Yes ( ) No

Where / how do you eat the following meals on a typical day: (Circle all that apply)

Breakfast:
- At the kitchen table
- Watching TV
- In the car
- Standing up
- At work
- Restaurant/ fast food
- Do not eat breakfast

Lunch:
- At the kitchen table
- Watching TV
- In the car
- Standing up
- At work
- Restaurant/ fast food
- Do not eat lunch

Dinner:
- At the kitchen table
- Watching TV
- In the car
- Standing up
- At work
- Restaurant/ fast food
- Do not eat dinner

Snacks:
- At the kitchen table
- Watching TV
- In the car
- Standing up
- At work
- Do not eat snacks

Do you eat with others? ( ) Yes ( ) No

Do you cook? ( ) Yes ( ) No

Who usually prepares the food at home?

_____

What activities / hobbies do you have?

_____

_____

_____

Are you active in day to day life? ( ) Yes ( ) No

Specify:

_____

_____

_____

Do you exercise? ( ) Yes ( ) No

If yes, how many days per week do you exercise?

_____

Type and duration of exercise

_____

_____

_____

What are your favorite foods?

_____

_____

What foods do you dislike?

_____

_____

What would you like to change about your eating habits?_____

_____

FOOD FREQUENCY QUESTIONAIRE

How often do you eat the following foods **per week**?

Food	Times Per Week	Food	Times Per Week	Food	Times Per Week
Eggs		Bread		Sweets	
Cheese		Nuts		Ice Cream	
Milk (Specify)		Rice/Pasta		Water	
Yogurt		Beans		Coffee/Tea	
Cottage Cheese		Bacon/Sausage		Carbonated Beverages	
Pizza		Potatoes		Energy Drinks	
Red Meat		Sweet Potatoes		Alcohol	
Chicken/Turkey		Frozen Dinners		Fruit Juice	
Fish		Fried Foods		Vegetables	
Soy Products		Restaurants		Corn, Peas, Lima Beans	
Luncheon Meat		Fast Food/Take out		Dietary Supplements	
Hotdogs		Salty Snacks		Ethnic Foods (Explain)	
Oatmeal/ oat bran		Margarine/Butter		Other:	

24-Hour Recall

Please indicate what you eat and drink on a "typical day."

	Time of Day	Food eaten (Please describe and include quantity of each item)
Breakfast		
Lunch		
Dinner		
Snacks		