



UNIVERSITY HEALTH SERVICES
NUTRITION CONSULTATION SHEET

Name: _____ Date: _____ Year in School: _____

*Please note that all disclosed information is confidential within UHS.

Referred by:

- Self Health care provider.....Name? Coach Other:

Why do you want to see the nutritionist? (Check all that apply)

- General healthy eating advice Sport nutrition advice High cholesterol
Want to lose weight Vegetarian eating High blood pressure
Want to gain muscle/weight Disordered eating/eating concerns Diabetes
Other (please explain): _____

Age: _____ Height: _____ ft _____ in Current Body Weight: _____ lbs

Lowest adult weight: _____ lbs When? ____/____ (month/year)

Highest adult weight: _____ lbs When? ____/____ (month/year)

How long have you been at your current weight? _____

Do you feel that you are at your ideal weight? Y N If not, what is your desired weight? _____ lbs

Where do you eat most of your meals? (Check all that apply)

- Dining Hall (please specify: _____) Self Preparation
Eating Club (please specify: _____) Frist Campus Center
Restaurants (please specify: _____)

How many times per day (meals + snacks) do you eat? _____ How many days per week do you eat breakfast? _____

What meal is generally a) your largest meal? _____ b) the meal most frequently skipped? _____

Do you follow any special diet or food pattern (e.g. low-fat, vegetarian, religious guidelines)? Y N If yes, please describe: _____

Does your food or weight feel out of control? Y N

Do you consciously limit or avoid any of the following foods: (Check all that apply)

- Red meat Milk Sweets Butter/margarine
Chicken Cheese Grains (i.e. rice, pasta) Other(s) - please list:
Seafood Oils/dressings Breads
Turkey Vegetables Fast food

How many servings of fruit do you eat per day? (please circle) a) 0 to 1 b) 2 to 3 c) 4 to 5 d) > 5
(ONE SERVING = 1 tennis ball sized piece of fruit OR 1 cup chopped fruit OR 1/2 cup (4 oz) 100% fruit juice)

How many servings of vegetables do you eat per day? (please circle) a) 0 to 1 b) 2 to 3 c) 4 to 5 d) > 5
(ONE SERVING = 1/2 cup cooked vegetables OR 1 cup raw vegetables OR 1/2 cup (4 oz) vegetable juice)

Do you drink caffeinated beverages (i.e. coffee, tea, soda)? Y N Amount daily? _____

Do you drink alcoholic beverages? Y N Describe use: _____

Do you take any vitamin, herbal, or nutritional supplements? Y N List: _____

Are you taking any medications (over-the-counter or prescriptions)? Y N
List each and reason for taking: _____

PLEASE TURN OVER ->

Do you commonly experience any of the following symptoms? (Check all that apply):

- Fatigue
- Light-headedness
- Frequent illness or injury
- Cold sensitivity
- Extreme hunger
- Decreased ability to concentrate
- Loss of appetite
- Irritability or moodiness
- Thinking about food alot

On average, how many hours do you sleep per night? _____ hours/night

What time do you generally go to bed? _____ am/pm

What time do you generally wake-up? _____ am/pm

If you are a student-athlete, please specify which team: _____

List any exercise/activity that you do on a regular basis:

Type of activity:	Frequency (days/week):	Duration (length of workout):	Intensity (light, moderate, high):

Have you ever used any of the following means to control body weight? (Check all that apply)	
Dieting/Fasting	<input type="checkbox"/>
Skipping meals	<input type="checkbox"/>
Purging	<input type="checkbox"/>
Laxative use	<input type="checkbox"/>
Diuretics	<input type="checkbox"/>
Dietary Supplements (e.g. fat-burners)	<input type="checkbox"/>
Diet Pills	<input type="checkbox"/>
Ipecac	<input type="checkbox"/>
Excessive exercise	<input type="checkbox"/>
	<input type="checkbox"/>

Please indicate if you have ever been diagnosed with any of the following: (Check all that apply)	
Diabetes or Hypoglycemia	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>
High Cholesterol	<input type="checkbox"/>
Osteopenia or Osteoporosis	<input type="checkbox"/>
Iron Deficiency	<input type="checkbox"/>
Kidney problems	<input type="checkbox"/>
Thyroid Disorder	<input type="checkbox"/>
Eating Disorder	<input type="checkbox"/>
Food allergies of food intolerances	<input type="checkbox"/>
Other medical condition (specify: _____)	<input type="checkbox"/>

Describe changes, if any, that you have made to your eating and/or exercise habits. When did you implement these changes?

What do you hope to achieve as a result of nutrition counseling?

Rate how important this change is to you (0 not at all, 10 extremely): 0 1 2 3 4 5 6 7 8 9 10

Rate how confident you are to make this change at this time: 0 1 2 3 4 5 6 7 8 9 10

What barriers, if any, stand in the way of you achieving your nutritional goals?

FOR FEMALES ONLY:

1) Do you have regular menstrual periods? Y N

2) Have you ever lost your period for three months or longer? Y N

3) Do you take oral contraceptives? Y N