

CAROLINAS WEIGHT MANAGEMENT AND WELLNESS CENTER

Nutrition History Worksheet

Please complete this form as accurately as possible as this will help us develop a plan for you.

Name: _____ DOB: ____/____/____ Age: ____ Date: ____/____/____

Gender: _____ HT: _____ WT: _____ Ideal Body WT: _____ Goal/Acceptable WT: _____

History:

1. When did you first notice you were overweight or started dieting? _____

Current Diet Information:

1. Current Diet: _____

Note: *If you are not on any specific diet plan and just eating foods you like, this would be called a "regular diet".*

2. Food allergies/intolerances: _____

3. What happens when you eat this food? _____

4. How many times a day do you eat? Meals: _____ Snacks: _____

5. How many times a week do you eat at restaurants or fast-food restaurants, eat-in or take-out?

Breakfast: _____ Lunch: _____ Dinner: _____

6. How many times per week do you skip a meal?

Breakfast: _____ Lunch: _____ Dinner: _____

7. Do you do most of the cooking in the home? YES NO

Fluid Intake:

1. Water intake per day (in ounces): _____

2. Calorie containing beverages such as soda, sports drinks, or juice consumed per day (in ounces): _____

3. Diet beverages such as diet soda, Crystal light, sugar-free Kool-aid consumed per day (in oz.): _____

Emotional Eating (check yes or no, then answer questions)

Are there any emotional factors that influence your eating? YES NO

For example: "I eat sweets when I'm stressed" or "If I've had a hard day at work I treat myself with my favorite Fast food" or "When I'm upset, I tend to snack more on "junk food" that when I'm not upset about something".

1. Describe any emotions that may influence your eating habits:

2. List any Comfort Foods or specific foods you choose when feeling these emotions:

3. Do you ever eat until you feel miserable or lose control of eating? YES NO

If yes, please describe.

4. Do you ever get up to eat in the middle of the night? YES NO

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5. Do you struggle with hunger? YES NO
6. Do you get most of your calories after 5PM? YES NO
7. Do you have specific food cravings?
If yes, describe: _____
8. What do you feel have been barriers to losing weight?

Dietary Recall (Please list 3 different choices for each meal. Also, list the times you eat)

What do you normally eat and drink? Be as specific as possible, listing food and amount as this is important in developing a plan specific for you.

	Breakfast	Mid-morning Snack	Lunch	Mid-afternoon Snack	Dinner	Evening Snack
Ex:	1 egg, 1 c. grits, 8 oz. orange juice	None	Chick Filet grilled chicken sandwich, small fries, 16 ounce sweet tea	8 ounces yogurt, 5 candy Kisses, Diet Coke	Small salad, 2 pc. Cheese pizza, 16 ounces water	Apple, 6 oreo cookies, 6oz. skim milk
1.	Times	Times	Times	Times	Times	Times
2.						
3.						

THANK YOU FOR TAKING THE TIME TO FILL OUT THE NUTRITION HISTORY WORKSHEET. WE APPRECIATE YOU BEING SPECIFIC AND DETAILED IN THE INFORMATION PROVIDED.



**Carolinas Weight Management
& Wellness Center**

NUTRITION HISTORY WORKSHEET

Patient Information or Sticker

Name:

DOB:

Medical Record #: