DENVER INDIAN HEALTH AND FAMILY SERVICES
2880 W. Holden Pl. Denver, CO 80204 **Ph** (303) 953-6600 **F** (303) 781-4333 www.dihfs.org

Nutrition Counseling Intake Form
Diabetes Management and Disease Prevention Program

All information received on this form will be treated as strictly confidential. Please fill out the form ***completely and accurately***. This information is essential to helping the nutritionist develop a wellness program that addresses your needs, goals and interests and is safe and effective.

Have you ever been seen in the DIHFS medical clinic before? ☐ Yes ☐ No
Do you already have a medical history on file? ☐ Yes ☐ No

Demographics			
Full Name		Gender	☐ Male ☐ Female
Date of Birth		Age	
Mailing Address			
Phone #			☐ home ☐ work ☐ cell
Email Address			
Occupation/work			
Family Status	☐ single ☐ dating ☐ married ☐ divorced/separated ☐ widowed ☐ children		

Concerns	
What health and/or nutrition concerns would you like to focus on during your visit?	
1	
2	
3	

Allergies		**Allergic Symptoms Experienced**
Food		
Medication		
Supplement		
Environmental		

Medications and Supplements			
Medication Name	Year Started	Dose/Frequency	Reason

Family History			
Have any of your close relatives (parents, siblings, grandparents, children) been diagnosed with the following? Please check, describe, and provide age of onset for those that apply.			
Condition	**Yes**	**Family Member**	**Age of onset**
Heart Disease	☐		
High Blood Pressure	☐		
Stroke	☐		
Diabetes	☐		
Cancer	☐		
Overweight/Obese	☐		
Food Intolerance	☐		
Autoimmune Disease	☐		

Lifestyle Information		
Do you engage in physical activity on a regular basis? ☐ No ☐ Yes; please describe:		
Activity	**Number of Days**	**Duration (minutes) per sessions**
How many hours do you sleep on weeknights? ☐ <6 ☐ 6-8 ☐ 8-10 ☐ 10+		
How many hours do you sleep on weekends? ☐ <6 ☐ 6-8 ☐ 8-10 ☐ 10+		
Check which apply to you: ☐ Trouble falling asleep ☐ Wake up during the night ☐ Don't feel rested		
Do you smoke?	☐ No ☐ Yes; how many cigarettes per day/week?	
Do you drink alcohol?	☐ No ☐ Yes; how many drinks per day/week?	
Have you ever experienced any major loses in life? ☐ No ☐ Yes – please explain.		

DENVER INDIAN HEALTH AND FAMILY SERVICES
2880 W. Holden Pl. Denver, CO 80204 **Ph** (303) 953-6600 **F** (303) 781-4333 www.dihfs.org

Nutrition History
Have you ever had an appointment with a dietitian or nutritionist? ☐ No ☐ Yes
Are you currently following a particular diet or nutrition plan? ☐ No ☐ Yes; please describe
Do you avoid any particular foods? ☐ No ☐ Yes; please describe

Nutrition History (continued)			
Height:	Height:	Usual Weight:	Desired weight:
Have you recently lost or gained weight? ☐ No ☐ Yes; please describe			
Do you have, or have you had, an eating disorder? ☐ No ☐ Yes; please describe			
Meal per day?		Snacks per day?	
How many meals do you "eat out" per week? ☐ 0-1 ☐ 2-3 ☐ 4-5 ☐ 6+			
What is your favorite meal?			
Check all the factors that apply to your eating habits and current lifestyle:			
☐ Love it eat ☐ Love to cook ☐ Emotional eater ☐ Late night eater ☐ Struggle with eating issues ☐ Family member have different tastes ☐ Dislike cooking	☐ Fast eater ☐ Erratic eating patterns ☐ Eat too much ☐ Rely on convenience foods ☐ Eat fast food frequently ☐ Make poor snack choices ☐ Confused about nutrition ☐ Dislike healthy food	☐ Live alone/eat alone often ☐ Do not plan meals/menus ☐ Time constraints ☐ Budget constraints ☐ Travel frequently ☐ Eat only because I have to ☐ Negative relationship with food	

DENVER INDIAN HEALTH AND FAMILY SERVICES
2880 W. Holden Pl. Denver, CO 80204 **Ph** (303) 953-6600 **F** (303) 781-4333 www.dihfs.org

Daily Intake Summary	
What types of proteins do you eat most days of the week? (check all that apply) ☐ animal meat ☐ poultry ☐ eggs ☐ beans ☐ dairy ☐ nuts ☐ fish/seafood	
How many servings of fruit do you have per day?	
How many serving of vegetables do you have per day?	

Provide an estimate of the amount of each beverage that you consume on an average day?

Water	_____ cups	Regular soda	_____ cups	Kool-aide/punch	_____ cups
Coffee	_____ cups	Diet soda	_____ cups	Milk	_____ cups
Tea	_____ cups	Juice	_____ cups	Sweet Tea	_____ cups

Health Goals	
What are two of your health goals and/or aspirations?	
1	
2	

Other
Is there anything else you would like to add?

Please bring this completed form to your first visit!