**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.

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

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| **Demographics** |
| **Full Name** |  | **Age:** |  |
| **Date of Birth** |  | **Gender:** | ☐Male☐ Female ☐ Non-binary |
| **Mailing Address** |  |
| **Phone #** | ☐home☐work ☐ cell |
| **Email Address** |  |
| **Occupation/work** |  |
| **Tribal Enrollment** | ☐ No ☐ Yes – tribe: |
| **Family Status** | ☐single ☐dating ☐married ☐divorced/separated☐widowed☐ domestic partnership ☐children |

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

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

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| **Medications and Supplements** |
| **Medication Name** | **Year Started** | **Dose/Frequency** | **Reason** |
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| **Lifestyle Information** |
| Do you engage in physical activity on a regular basis?☐ No☐ Yes; please describe:  |
| **Activity** | **Number of Days** | **Duration (minutes) per sessions** |
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| 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. |

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| **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 |

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| **Nutrition History (continued)**  |
| Height:  |  Current Weight: | Desired weight: |
| Have you recently lost or gained weight?  |  ☐ No☐ Yes; please describe |
| Do you have (or had, in the past) an eating disorder?  |  ☐ No☐ Yes; please describe |
| Meals per day?  | Snacks per day? |
| How many meals do you “eat out” per week? ☐ 0-1☐ 2-3 ☐ 4-5 ☐ 6+ |
| Check all the factors that apply to your eating habits and current lifestyle: |
| ☐ Love to eat☐ Love to cook☐ Emotional eater☐ Late night eater☐ Struggle with eating issues☐ Hate cooking☐ Dislike “healthy” food | ☐ Fast eater☐ Erratic eating patterns☐ Eat too much☐ convenience foods☐ Eat fast food frequently ☐ Make poor snack choices☐ Confused about nutrition | ☐ Live alone/eat alone often☐ Do not plan meals/menus☐ Time constraints☐ Budget constraints☐ Travel frequently ☐ Eat only because I have to☐ Afraid of food  |

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| **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 servings of vegetables do you have per day? |  |
| Provide an estimate of the amount of each beverage that you consume on an average day? |
| WaterCoffeeTea | \_\_\_\_\_ cups\_\_\_\_\_ cups\_\_\_\_\_ cups | Regular sodaDiet sodaJuice | \_\_\_\_\_ cups\_\_\_\_\_ cups\_\_\_\_\_ cups | Kool-aide/punchMilkSweet Tea | \_\_\_\_\_ cups\_\_\_\_\_ cups\_\_\_\_\_ cups |

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| **Traditional Foods and Food-Patterns** |
| **Are you familiar with traditional foods?** ☐No ☐ Yes;  |
| **If Yes** -- What does “traditional foods” mean to you? |
| **Did you eat traditional foods growing up?** ☐No ☐ Yes; |
| **If Yes** -- What types of traditional foods did you eat growing up? |
| **Do you eat traditional foods now?** ☐No ☐ Yes; |
| **If Yes** – What types of traditional foods do you eat now? |
| **How important is it for you to consume traditional foods?**☐Not important☐Somewhat important ☐Very important |

***Please bring this completed form to your first visit!***