Thriving After Cancer Program - Nutrition Intake

Please complete the following questionnaire as thoroughly as possible. This will become a part your confidential medical record and will not be released unless you authorize the release. Please print clearly.

Today's Date: _____

Age	Gender ☐ Male ☐ Female

GOALS AND READINESS

Please complete the following:

I would like to visit with the dietitian today because. . .

My top three food and nutrition related goals are. . .

1.

2.

3.

My overall health goals are. . .

The biggest challenge(s) to reaching my nutrition goals is/are. . .

In the past, I've tried the following diets or dietary restrictions, rules or behaviors, etc to reach my nutrition goals. . .

Please describe any recent dietary changes:

Regarding your readiness to change your nutrition, which statement most closely describes you?

☐ I am not considering any nutritional changes at this time.
☐ I am considering nutritional changes, but am not ready to take action.
☐ I am early into the process of making nutritional changes
☐ I am well into the process of making nutritional changes.
☐ I am maintaining prior changes that I've implemented.

MEDICATION USE

Please list all current medications and length of time you've been taking them:

Medication	Dose	Duration

NUTRITIONAL SUPPLEMENTS/VITAMINS/HERBS

Please list all current nutrition supplement, herbs or vitamins and length of time you've been taking them:

Nutritional Supplement/Herb/ Vitamin	Reason for Taking	Dose	Duration

CURRENT MEDICAL CONDITIONS

Please provide the year of onset of any conditions which apply to you.

Condition	Year	Condition	Year
Anemia		Gastrointestinal Disorder	
Arthritis		High Blood Pressure	
Cholesterol		Hyperthyroid	
Diabetes		Overweight/Obesity	
Eating Disorder		Hypoglycemia	
Food Allergies		Hypothyroid	
Heart Disease		Lyme Disease	
Infertility		Other, please specify:	
Osteoporosis/Osteopenia			

DIGESTION/ELIMINATION ISSUES

Please indicate the frequency and year of any conditions which apply to you:

Condition	Frequency	Year	Condition	Frequency	Year
Abdominal or stomach Pain			Flatulence or gassiness		
Belching or burping			Heartburn or acid reflux		
Change in appetite or thirst			Nausea		
Cramping after eating			Vomiting		
Diarrhea			Painful stool		
Constipation			Blood in stool		

FOOD ALLERGIES AND FOOD SENSITIVITIES

Please list any food allergies/sensitivities and the specific reactions.

FOOD HISTORY

Please indicate how many servings you have of per day and per week:

Food/Bev/Misc	Per/day	Per/week	Food/Bev/Misc	Per/day	Per/week
Cigarettes/cigars			Red Meat (3 oz)		
Coffee (8 oz)			Chicken/Turkey (3 oz)		
Wine (4oz)			Fish (3 oz)		
Hard liquor/mixed drinks (1.5 fl oz liquor)			Veggies (green) (1 cup)		
Beer (12 oz)			Legumes/beans (1 cup)		
Dairy Products (8 oz)			Fruits (1 cup)		
Water (12 oz)			Starchy Vegetables (1/2 cup)		
Tea – Green, Black, White, Herbal (8 oz)			Sweets/Desserts (1.4 oz = 1 medium cupcake)		
Sodas (12 oz)			Other:		

EATING PATTERNS

How many meals do you eat each day?

How many snacks do you eat each day?

Do you or does anyone in your household cook on a regular basis?

What cooking methods do you or your family use most?

☐ Fry ☐ Bake ☐ Grill ☐ Sautee ☐ Steam ☐ Microwave

How many times a week do you eat breakfast?

How many times a week do you sit down to dinner?

What percentage of your weekly meals is home-prepared?

How many meals do you eat out per week on average? (please include snacks)

What percentage of your daily food intake is made up of convenience foods? (e.g. chips, cookies, frozen meals, etc.)

My diet can best be described as:

☐ Omnivore; I eat meats, poultry, fish, eggs, dairy, fruits, grains, and vegetables.
☐ Semi-vegetarian; I exclude some animal products, specifically: _____
☐ Ovo-lacto-vegetarian; I exclude meat, poultry and fish, but include dairy and eggs.
☐ Vegan; I exclude all animal products.
☐ Other, please explain: _____

WEIGHT & BODY MEASUREMENTS

Current Weight (pounds)		Goal Weight (pounds)	
Current Height (inches)		I consider myself to be:	☐ Underweight ☐ Normal ☐ Slightly overweight ☐ Very overweight
Weight 5 yrs ago (if known)			

Have you had any recent weight changes? If so, please explain:

SLEEPING HABITS

Please answer the following questions about a typical night's sleep.

At what time do you typically go to sleep?

How many hours do you sleep each night?

What time do you wake up?	Do you stay asleep? ☐ Yes ☐ No
Do you fall asleep right away? ☐ Yes ☐ No	Do you wake rested? ☐ Yes ☐ No

PLEASE RATE YOUR ENERGY LEVEL

Please rate your energy level on a typical day on a scale from 0-10 where:

No energy					Some energy					Extremely energetic
0	1	2	3	4	5	6	7	8	9	10

Time of day:	Rating (0-10) and explanation:
First wake up	
Around noon	
Afternoon	
Evening	

STRESS LEVEL

Please rate your stress level on a typical day on a scale from 0-10 where:

No stress					Some stress					Extreme stress
0	1	2	3	4	5	6	7	8	9	10

What do you consider your typical stressor(s)?

☐ Work
☐ Family
☐ Social
☐ Other, please specify:
☐ Financial
☐ Health

Please supply any additional information about your typical stressors that you would like to share:

EXERCISE HABITS

Please list the type of exercise, duration, and time per week you complete this type of exercise:

Type of exercise	Duration (minutes/hours)	Times per week

Do you have any other questions, concerns, or comments?