

Nutrition and Weight Management Initial Visit

Name: _____ Date : _____ Chart # _____

Weight Loss History

Highest Adult Weight _____ Lowest Adult Weight _____ Desired Weight _____

Please indicate which of these diets you have tried in the past:

South Beach Weight Watchers Jenny Craig Atkin's Diet NutriSystem Other: _____

Have you gained or lost more than 10 lbs. In the past 5 years?

Yes, more than once Yes, only once No, my weight has remained stable

If yes, by how much has your weight fluctuated? _____

Do you currently have or have you ever had any of the following medical conditions?

Type I Diabetes Type II Diabetes Lactose Intolerance High Blood Pressure

Heart Disease Gastritis Stomach Ulcer Cancer: _____

Celiac Disease Diverticulosis Kidney Disease Phenylketonuria Pancreatitis

Exercise/Physical Activity

How often do you exercise each week? _____ How long do you exercise for? _____ min.

What exercises/activities do you do? _____

On a scale of 1 – 10 what is the average intensity of your workout?

1 (easy to talk while exercising) 2 3 4 5 6 7 8 9 10 (difficult to tak while exercising)

How often do you cardio exercises? _____ How often do you lift weights? _____

Initial Measurements

Ht: _____ Wt: _____ BMI: _____ Age: _____ BP: _____

Current Medications: _____

Drug Allergies: _____

Initial Plan

Exercise:

Diet:

Medications:

Follow-up:

Provider: _____
