SUNY Cortland Nutrition Services – Information Sheet

General Information

Name:_____ Date:_____

Birth date:_____ Age:_____ Sex:_____

Email:_____ Phone:_____

Major:_____ Do you live: ☐ On campus ☐ Off campus

Year in school: ☐ Freshman ☐ Sophomore ☐ Junior ☐ Senior ☐ Grad ☐ Faculty/staff

How were you referred for nutrition counseling: ☐ Self ☐ Friend ☐ RA/RHD ☐ Parent

☐ Counseling center ☐ Health services ☐ Other_____

Nutrition and Dietary Questions

Height:_____ Weight:_____ Desired weight range:_____

Have you had any significant weight changes in the past year (gained/lost >10#)?

If yes, please explain:_____

How would you describe your eating habits? ☐ good ☐ fair ☐ poor

How has your appetite been lately? ☐ hearty ☐ good ☐ fair ☐ poor

How often do you eat fewer than 3 times a day? ☐ daily ☐ weekly ☐ rarely ☐ never

Does your food intake or weight feel out of control? ☐ no ☐ yes

Do you consume alcohol? ☐ no ☐ yes How many drinks a week? ☐ 1-2 ☐ 3-5 ☐ 6-8 ☐ >8

Do you smoke? ☐ no ☐ yes If yes, would you like to quit? ☐ no ☐ yes

Do you follow a special diet (vegetarian, gluten free, Weight Watchers, etc.)? ☐ no ☐ yes

If yes, please explain:_____

Do you have food allergies or intolerances? ☐ no ☐ yes If yes, please explain:_____

_____

Are there other foods you avoid? Please explain what/why:_____

_____

Do you have frequent: ☐ diarrhea ☐ constipation ☐ heartburn ☐ gas/bloating

Where do you eat most of your meals during the week?_____

On weekends?_____

How many days/week do you engage in moderate to vigorous activity for at least 30 minutes?

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 Are you on a team? Which?_____

How many hours of sleep do you get on an average night?_____ Naps?_____

Why are you coming for nutrition counseling and what do you hope I can do for you?_____

_____

Have you worked with a Nutritionist or Registered Dietitian before? If yes, please explain:_____

_____

Medication, Dietary Supplement, and Drug Use:

Are you currently taking any of the following? If so, please list:

Type of medication, supplement, or drug	***Yes/no***	***Brand name***	***Dose/frequency***	***Reason for use***
Prescription drugs				
Over the counter medications				
Vitamin/mineral supplements				
Herbal supplements				
Meal replacements				
Other				

Medical Information

Are you currently being treated for a medical condition? If yes, please explain:_____

_____

Have you ever been told by a medical provider that you have the following:

Bone/stress fracture ☐ no ☐ yes
Diabetes ☐ no ☐ yes ☐ Type I ☐ Type II
Digestive disorder ☐ no ☐ yes ☐ Celiac ☐ Crohn's ☐ Other:_____
Eating disorder ☐ no ☐ yes ☐ Anorexia ☐ Bulimia ☐ Binge eating disorder
High blood pressure ☐ no ☐ yes
High cholesterol ☐ no ☐ yes
Iron deficiency anemia ☐ no ☐ yes

Do you have a family history of any of the following:

Cancer ☐ no ☐ yes What kind:_____
Diabetes ☐ no ☐ yes ☐ Type I ☐ Type II
High blood pressure ☐ no ☐ yes
High cholesterol ☐ no ☐ yes

Females: do you have regular periods? ☐ yes ☐ no About how often:_____

Is there any other information that you think would be helpful for me to know?_____

_____

_____

Information verification

I verify that the above information is accurate and complete.

Name (print):_____ Date:_____

Signature:_____

Food log

Please record all food and beverages consumed within one 24-hour period. Pick a day which is typical of how you eat on a regular basis. Please include how the food is prepared (baked, fried, etc.), condiments (butter, salad dressing, etc.), sauces, sweeteners, etc., amount consumed, and where it was consumed. Please fill this out as accurately and completely as you can.

Time	**Place**	**Food or drink** (incl. condiments, how prepared, etc.)	**Amount**