campus HEALTH

Nutrition Initial Intake Form

Date completed: ______/______/______

PERSONAL INFORMATION

Legal Name *(Last, First, MI)*: ______________________________________ DOB: ___ /____/____ PID: _________________

Preferred Name: ____ Pronouns: ______________________________

Sex assigned at birth: ○ Female ○ Male ○ Intersex / Ambiguous

How do you describe yourself? ○ Female ○ Male ○ Trans Female ○ Trans Male ○ Genderqueer / non-conforming

○ Other *(please specify)*:______________________________ ○ Prefer not to respond

Reason for visit today: ____

MEDICATIONS List with doses. Include contraceptives (pill, IUD, Nexplanon), vitamins, supplements, etc. ○ **None**

____ ____
____ ____
____ ____

ALLERGIES List medication, food, insect or latex allergies and the type of reaction you had ○ **I have no allergies**

____ ____
____ ____

SURGERIES AND HOSPITALIZATIONS List what types and dates ○ **None**

____ ____
____ ____

SOCIAL HISTORY AND EXERCISE

Alcohol

Do you ever drink alcohol? ○ No ○ Yes, how many times a **week**? ________ How many drinks per sitting? ______

Tobacco and drugs

Do you use tobacco (cigarettes, cigars, hookah, pipe, bidis, kreteks) ○ No ○ Yes, what type(s)? ________________
Do you use smokeless tobacco (chewing, snuff, dip, dissolvable) ○ No ○ Yes, what type(s)? __________________
Do you use e-cigs such as vaping ○ No ○ Yes
How many times a **week** do you use ***any*** of the above? ____

Do you use recreational drugs? ○ No ○ Yes, what type of drug(s): _______________________________________
How many times a **week** do you use ***any*** of the above? ____

Routine Exercise/Movement (including walking) (Note type, how often, and duration)

____
____
____

YOUR MEDICAL CONDITIONS (check all that apply)

- ☐ Anemia
- ☐ Anxiety/Depression/Bipolar
- ☐ Asthma
- ☐ Autoimmune disease
- ☐ Cancer *(type)* ____________
- ☐ Crohn's or Ulcerative Colitis
- ☐ Diabetes mellitus (type) ____
- ☐ DVT or PE
- ☐ Eating disorder
- ☐ Epilepsy (Seizures)
- ☐ Heart disease or condition
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Kidney stone or disease
- ☐ Liver disease, hepatitis, tumor
- ☐ Migraine headaches
- ☐ Thyroid disorder
- ☐ Other:____________________________

DIET

Do you have any dietary restrictions? ◯ **Yes** ◯ **No**

If yes, describe: ____

____

Do you experience or anxiety, fear, guilt, or shame around food ◯ **Yes** ◯ **No**

If yes, describe: ____

____

What did you eat and drink yesterday?

Time	Type of food/drink and Amount Consumed
eg. 8a	Plain bagel with about 2 tablespoons of peanut butter + 1 banana + 1 glass water

Eating Attitudes Test (EAT-26)©

Instructions: This is a screening measure to help you determine whether you might have an eating disorder that needs professional attention. This screening measure is not designed to make a diagnosis of an eating disorder or take the place of a professional consultation. Please fill out the below form as accurately, honestly and completely as possible. There are no right or wrong answers. All of your responses are confidential.

Part A: Complete the following questions:

1) Birth Date	Month:		Day:		Year:		2) Gender:
3) Height	Feet :		Inches:				
4) Current Weight (lbs.):			5) Highest Weight (excluding pregnancy):				
6) Lowest Adult Weight:			7: Ideal Weight:				

	Part B: Check a response for each of the following statements:	Always	Usually	Often	Some times	Rarely	Never
1.	Am terrified about being overweight.	□	□	□	□	□	□
2.	Avoid eating when I am hungry.	□	□	□	□	□	□
3.	Find myself preoccupied with food.	□	□	□	□	□	□
4.	Have gone on eating binges where I feel that I may not be able to stop.	□	□	□	□	□	□
5.	Cut my food into small pieces.	□	□	□	□	□	□
6.	Aware of the calorie content of foods that I eat.	□	□	□	□	□	□
7.	Particularly avoid food with a high carbohydrate content (i.e. bread, rice, potatoes, etc.)	□	□	□	□	□	□
8.	Feel that others would prefer if I ate more.	□	□	□	□	□	□
9.	Vomit after I have eaten.	□	□	□	□	□	□
10.	Feel extremely guilty after eating.	□	□	□	□	□	□
11.	Am preoccupied with a desire to be thinner.	□	□	□	□	□	□
12.	Think about burning up calories when I exercise.	□	□	□	□	□	□
13.	Other people think that I am too thin.	□	□	□	□	□	□
14.	Am preoccupied with the thought of having fat on my body.	□	□	□	□	□	□
15.	Take longer than others to eat my meals.	□	□	□	□	□	□
16.	Avoid foods with sugar in them.	□	□	□	□	□	□
17.	Eat diet foods.	□	□	□	□	□	□
18.	Feel that food controls my life.	□	□	□	□	□	□
19.	Display self-control around food.	□	□	□	□	□	□
20.	Feel that others pressure me to eat.	□	□	□	□	□	□
21.	Give too much time and thought to food.	□	□	□	□	□	□
22.	Feel uncomfortable after eating sweets.	□	□	□	□	□	□
23.	Engage in dieting behavior.	□	□	□	□	□	□
24.	Like my stomach to be empty.	□	□	□	□	□	□
25.	Have the impulse to vomit after meals.	□	□	□	□	□	□
26.	Enjoy trying new rich foods.	□	□	□	□	□	□

	Part C: Behavioral Questions: In the past 6 months have you:	Never	Once a month or less	2-3 times a month	Once a week	2-6 times a week	Once a day or more
A	Gone on eating binges where you feel that you may not be able to stop? *	□	□	□	□	□	□
B	Ever made yourself sick (vomited) to control your weight or shape?	□	□	□	□	□	□
C	Ever used laxatives, diet pills or diuretics (water pills) to control your weight or shape?	□	□	□	□	□	□
D	Exercised more than 60 minutes a day to lose or to control your weight?	□	□	□	□	□	□
E	Lost 20 pounds or more in the past 6 months	Yes □		No □			

* Defined as eating much more than most people would under the same circumstances and feeling that eating is out of control

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