MARIN GENERAL HOSPITAL
CENTER FOR INTEGRATIVE HEALTH & WELLNESS

1350 S. ELISEO
GREENBRAE, CA 94904
415-925-7620

CENTER FOR INTEGRATIVE HEALTH & WELLNESS
NUTRITION ASSESSMENT/ INTAKE FORM

All information provided will be kept completely confidential for the exclusive use of Marin General Hospital's Center for Integrative Health & Wellness staff, practitioners and/or physicians in order to provide you the best possible care.

Today's Date: _____

Patient's Name: Mr. / Mrs. / Ms (*circle one*) _____

Address: _____ **City**: _____ **Zip**: _____

Phone (Home): _____ **(Cell):** _____

Email: _____@_____ **Occupation**: _____

What is the BEST way to communicate with you between office visits:

☐ Home phone ☐ Cell phone ☐ Email

Is there any place you DO NOT want us to leave a message? _____

Age: _____ **Birth Date**: _____

Primary Physician's Name: _____ **Phone**: _____

Emergency Contact Name / Relation: _____ **Phone**: _____

GOALS AND READINESS ASSESSMENT

I would like to visit with the dietitian, today because…

_____

_____

_____

My food and nutrition-related goals are…

_____

_____

_____

My overall, health goals are…

_____

_____

_____

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

_____

_____

_____

In the past, I have tried the following techniques, diets, behaviors, etc. to reach my nutrition goals…

_____

_____

_____

On a scale of 1 (not willing) to 5 (very willing), please indicate your readiness/willingness to do the following:

To improve your health, how ready/willing are you to…	**1**	**2**	**3**	**4**	**5**
Modify your diet					
Take nutritional supplements each day (if appropriate)					
Keep a record of everything you eat each day					
Modify your lifestyle (ex: work demands, sleep habits, physical activity)					
Practice relaxation techniques					
Engage in regular exercise/physical activity					
Have periodic lab tests to assess your progress					

Please list the medications are you currently taking (prescription and/or over-the-counter): _____

_____

_____

_____

Do you take any vitamins or other dietary supplements? Yes/No
If yes, please list what they are, the brand and how often you take them.

Type of Supplement (e.g. vitamin D, fish oil etc)	**Brand** (e.g. Nature's way)	**Dose** (e.g. 1000 IU)	**How often?** **(e.g.** 1 x day, 1 x week)

PAST MEDICAL HISTORY

Please indicate whether you or your relatives* have been diagnosed with any of the following diseases or symptoms (specify which relative and the date of diagnosis). *Relatives include: parents, grandparents, siblings.

Illness/Disease/Symptom	Self: Age Diagnosed	Relative: Age Diagnosed	Describe/Specify
☐ Allergies (please specify type of allergy)			
☐ Anemia			
☐ Anxiety or Panic Attacks			
☐ Arthritis (osteoarthritis or rheumatoid)			
☐ Asthma			
☐ Autoimmune condition (specify type)			
☐ Cancer (specify type)			
☐ Chronic Fatigue Syndrome			
☐ Crohn's Disease or Ulcerative Colitis			
☐ Depression			
☐ Diabetes (Specify: Type I, II, Pre-diabetes, Gestational Diabetes)			
☐ Epilepsy, convulsions, or seizures			
☐ Eye Disease (please specify)			
☐ Fibromyalgia			
☐ Food Allergies or Sensitivities			
☐ Gallbladder Disease/Gallstones (specify)			
☐ Gout			
☐ Heart attack/Angina			
☐ Heartburn			
☐ Heart disease (specify)			
☐ Hepatitis			
☐ High blood fats (cholesterol, triglycerides)			
☐ High blood pressure (hypertension)			
☐ Hypoglycemia (low blood sugar)			
☐ Intestinal Disease (specify)			
☐ Inflammatory Bowel Disease (Crohn's or Ulcerative Colitis)			
☐ Irritable bowel syndrome			
☐ Kidney disease/failure or Kidney stones			
☐ Lung disease (specify)			
☐ Liver disease			
☐ Osteoporosis			
☐ PMS			
☐ Polycystic Ovarian Syndrome			

WEIGHT HISTORY

Would you like to be weighed today? Yes/No

Height _____ Current Weight _____ Desired Body Weight _____

Highest Adult Weight _____ When? _____ Weight 1 year ago _____

Have you had any recent changes in your weight that you are concerned about? Yes/No

If yes, please explain:_____

Has your weight changed in the last year? Yes/No
If yes, what was your weight one month ago _____ 6 months ago _____

USUAL FOOD INTAKE

Compared to your normal food intake, has your current food intake changed during the past month?
Unchanged _____ more than usual _____ less than usual _____

Have you recently changed the type of food you are eating? (If yes please explain)

_____

_____

_____

Please check any of the following problems which have kept you from eating adequately over the past 2 weeks

- ☐ Poor appetite
- ☐ Mouth sores
- ☐ Difficulty swallowing
- ☐ Pain on swallowing
- ☐ Pain in general (please site pain)
- ☐ Food tastes different
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ fatigue
- ☐ Dry mouth
- ☐ Smells bother me
- ☐ Feel full quickly
- ☐ Constipation

DIGESTIVE HISTORY

- **Do you associate any digestive symptoms with eating certain foods?** ☐ **Yes** ☐ **No**
  If yes, please explain:_____

  _____ _____
- **How often do you have a bowel movement? _____**
- **If you take laxatives, what type/brand and how often?**
  _____

MEAL PREPARATION

Who shops and prepares meals in your home?

How many meals do you eat away from home on weekdays? ____Breakfast ____ Lunch_____Dinner

How many meals do you eat away from home on weekends? _____Breakfast _____ Lunch_____ Dinner

List restaurants where you often eat?

_____

_____

3 DAY FOOD DIARY – Please keep a food diary for 3 days. Write down all the foods and drinks consumed. Please include how much (the amount you ate or serving size) and any information about how it was prepared (i.e. baked, grilled, sautéed).

Day 1	**Day 2**	**Day 3**
Breakfast	**Breakfast**	**Breakfast**
Lunch	**Lunch**	**Lunch**
Dinner	**Dinner**	**Dinner**
Snacks	**Snacks**	**Snacks**

EXERCISE & OTHER LIFESTYLE HABITS

What type of exercise do you most enjoy (e.g. walking, running, swimming)? _____

_____

How often do you exercise?

- ☐ 1-2 days / week
- ☐ 3-4 days / week
- ☐ 5-7 days / week
- ☐ I don't exercise very often because I don't really enjoy it
- ☐ I enjoy exercising but don't have time

For how long do you normally exercise?

- ☐ Less than 30 mins. / workout
- ☐ 30-45 mins. / workout
- ☐ >45 mins. / workout

What are your leisure activities / hobbies? _____

Do you drink alcoholic beverages? **Yes/No**

If yes how often? How many per day or per week? _____

Are you a smoker? Yes/No