TOTAL HEALTH CONCEPTS, LLC
(703) 255-7012 / FAX (703) 255-6171

Nutrition, Fitness, and Psychotherapy Professional Services

Please Print Clearly

Nutrition Assessment Form

Date_____/_____/_____

Last Name _____ First Name _____
Address: _____State_____Zip_____
Home Phone: _____Cell: _____Work: _____
Email Address: _____

Date of Birth: _____Age: _____Sex: M/F Height: _____Weight: _____
Occupation: _____
Marital Status: S M D W Years Married: _____
Emergency Contact:_____ Relation:_____ Phone #:_____

Please fill in the names and phone numbers of the professionals from whom you are currently receiving treatment

Physician:	Phone:
Psychiatrist:	Phone:
Therapist/Psychologist:	Phone:
Nutritionist:	Phone:
Other:	Phone:

Who referred you to Total Health Concepts? _____

Medical Diagnosis/ Primary Concerns_____

This comprehensive assessment provides us with information that assists us in helping clients with a variety of health issues. If you have difficulty or feel uncomfortable filling out any sections, leave them blank and your nutritionist or therapist will review them with you during your first session.

Personal Health Profile

Is there anything that surfaced during a recent medical test, lab work, or doctor's visit that you would like to report?

_____

_____

Have you / your family ever been treated for or have a history of:

	You	Parents	Siblings	Extended Family
Abdominal cramps	☐	☐	☐	☐
Alcoholism	☐	☐	☐	☐
Allergies	☐	☐	☐	☐
Alzheimer's	☐	☐	☐	☐
Anemia	☐	☐	☐	☐
Anorexia	☐	☐	☐	☐
Anxiety disorders	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐
Asthma	☐	☐	☐	☐
Behavioral problems	☐	☐	☐	☐
Bipolar Disorder	☐	☐	☐	☐
Birth defects	☐	☐	☐	☐
Bronchitis	☐	☐	☐	☐
Bulimia	☐	☐	☐	☐
Cancer	☐	☐	☐	☐
Chronic Fatigue Syndrome	☐	☐	☐	☐
Compulsive overeating	☐	☐	☐	☐
Congenital defects	☐	☐	☐	☐
Constipation	☐	☐	☐	☐
Depression	☐	☐	☐	☐
Developmental delays	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Diarrhea	☐	☐	☐	☐
Dizziness	☐	☐	☐	☐
Drug abuse	☐	☐	☐	☐
Edema	☐	☐	☐	☐
Emotional problems	☐	☐	☐	☐
Emphysema	☐	☐	☐	☐
Fibromyalgia	☐	☐	☐	☐
Gestational diabetes	☐	☐	☐	☐
Heart disease	☐	☐	☐	☐
Heart attack	☐	☐	☐	☐
Heart murmur	☐	☐	☐	☐
High blood pressure	☐	☐	☐	☐
High cholesterol/triglycerides	☐	☐	☐	☐
Hypoglycemia	☐	☐	☐	☐
Liver disease	☐	☐	☐	☐
Low blood pressure	☐	☐	☐	☐
Migraines	☐	☐	☐	☐
Nausea	☐	☐	☐	☐
Obesity	☐	☐	☐	☐
Osteoporosis/Osteopenia	☐	☐	☐	☐
Sexual dysfunction	☐	☐	☐	☐
Stroke	☐	☐	☐	☐
Thyroid Problems	☐	☐	☐	☐
Urinary tract infections	☐	☐	☐	☐

Other chronic or serious health problems/symptoms: _____

_____

Please list any hospitalizations / surgeries / in-patient treatments you have had and your age at the time:

_____

_____

_____

Medications/Supplements

Please list all current medications and dosage:

_____

_____

_____

Vitamin/Mineral Supplements: _____
Aspirin/Ibuprofen: _____
Other: _____

Females Only

Are you pregnant? Yes_____ No_____
If so, how many months? _____
Number of pregnancies: _____
Number of miscarriages: _____
Are you breastfeeding? Yes_____ No_____
Regular menstrual cycle: Yes_____ No_____
Age at which menstruation began: _____
Menstrual cycle irregular/stopped? Yes_____ No_____
At what age?_____

Nutritional Profile

Eating Behaviors
check all that apply:
_____ Use food as a reward/to pamper yourself?
_____ Eat to avoid coping with feelings? (stress, depression, boredom)
_____ Eat or snack late at night?
_____ Skip meals?
_____ Have an inconsistent meal pattern/timing?
_____ Overeat or eat past fullness?
_____ Eat at inappropriate times? (watching TV, driving, cooking dinner)
_____ Eat on the run? (fast food/convenience food/vending machine)
_____ Eat too fast or rush through meals?
_____ Binge or overeat without control?
_____ Purge by vomiting, using laxatives, or other method?
_____ Avoid major food groups?
_____ Avoid social eating?
_____ Fear of weight gain or loss?
_____ Frequently eat out?
_____ Crave salty foods?
_____ Crave sweets?
_____ Crave high carbohydrate foods?
_____ Use artificial sweeteners

Are you currently on a specific diet? Please explain:_____

Are you allergic to any of the following?
_____ Gluten _____ Egg _____ Milk _____ Dairy _____ Nuts _____ Seafood
Other: _____

Are there any other food groups you exclude?
_____ Fruit _____ Vegetables _____ Starches _____ Fats

Other: _____

Describe your past diets; include diet pills and/or laxatives, fad diets, liquid diets: _____
_____
Highest adult weight: _____ Lowest adult weight: _____ Most stable adult weight: _____

One Day Food Intake Journal

	Time	Activity and feelings (while eating)	Food/Beverages	Hunger scale (before/after)
Breakfast				
Snack				
Lunch				
Snack				
Dinner				
Snack				

Hunger Scale

1	2	3	4	5	6	7	8	9	10
Starved		Hungry		Comfortable		Full		Stuffed/ Uncomfortable	

Estimate how many servings of the following food groups you have daily:

	0-2	3-5	6-8	9+
Starches	☐	☐	☐	☐
Vegetables	☐	☐	☐	☐
Fruits	☐	☐	☐	☐
Dairy	☐	☐	☐	☐
Protein	☐	☐	☐	☐
Sweets	☐	☐	☐	☐

Personal Lifestyle Profile

Are you over-functioning, under-functioning, or balanced in the time you spend in the following areas?

	Over-functioning	Under-functioning	Balanced
Personal Time	☐	☐	☐
Work/Occupation	☐	☐	☐
Family Activity	☐	☐	☐
Social Activity	☐	☐	☐
Physical Activity	☐	☐	☐
Spiritual Activity	☐	☐	☐

Stress Profile

	Yes	No
Do you feel in control of your life?	☐	☐
Do you feel you have enough personal time?	☐	☐
Do you make time to relax at least 15 to 30 minutes per day?	☐	☐
Do you like your job/school?	☐	☐
Do you have friends and enjoy social events?	☐	☐
Do you find your family situation stressful?	☐	☐

Please indicate where your overall stress level currently falls on the scale:

Overall Stress Level

1	2	3	4	5	6	7	8	9	10
No stress			Minimal stress		Moderate Stress			Very High Stress	

Self-Esteem and Body Image Profile

My internal thoughts about myself are:
_____ Positive _____ Neutral _____ Negative
Describe: _____
_____

My confidence level is:
_____ High _____ Neutral _____ Low
Areas where I feel confident: _____
Areas where I do not feel confident: _____

Sleep Pattern:
How many hours do you sleep at night? _____
Do you have trouble falling asleep at night? How often and why? _____
_____
Do you wake up during the middle of the night? How often and why? _____
_____
Are you tired during the day? How often? _____
Do you sleep/nap during the day? How often and for how long? _____
_____

Drinking Behavior:
Do you drink alcoholic beverages: Yes ____ No ____
What kind: _____
How many per day? _____ Per week? _____
Do you drink caffeinated beverages: Yes ____ No ____
What kind: _____
How many per day? _____ Per week? _____
Do you drink sodas: Yes ____ No ____
What kind: _____
How many per day? _____ Per week? _____
Do you drink water: Yes ____ No ____
How many 8 oz glasses per day? _____

Summary of Personal Goals

What are your personal health goals? Check all that apply:

_____ Lose body weight/inches
_____ Improve nutritional quality and health
_____ Improved eating behaviors
_____ Reduce binging/purging
_____ Reduce compulsive overeating
_____ Stress management
_____ Reduce alcohol consumption
_____ Stop smoking
_____ Gain lean muscle mass
_____
Other:
_____
_____
_____

What are your personal nutritional goals?_____
_____
_____
_____

What expectations and goals do you have for your nutritional therapy?
_____
_____
_____
_____