FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

YMCA George Wellbeing Center
Nutrition Foundation Session

Please take time to answer this questionnaire and submit to your Nutritionist at least 24 hours before your appointment. Thank you!

First _____ M.I. _____ Last _____

Birthdate ____ / ____ / ____ ☐ I am 18 Years of age or older Date _____

PURPOSE

Why are you interested in meeting with a Nutritionist?

_____

What are your primary goals and/or expectations for working with a Nutritionist?

_____

FOOD & EATING HABITS

Are you currently following or have you ever followed a special food plan for health reasons or otherwise? ☐ Yes ☐ No

If Yes, describe plan. _____

Rate your motivation level (10=high) Low 1 2 3 4 5 6 7 8 9 10 High

Are you concerned about any eating behaviors (i.e. overeating, food restriction or binging)? ☐ Yes ☐ No

If Yes, describe concerns. _____

Do you have any food allergies, intolerances or sensitivities (milk, eggs, shellfish, tree nuts, peanuts, wheat, soybeans, etc.)? ☐ Yes ☐ No

If yes, what? Please list allergy, intolerance or sensitivity:

_____

Have these allergies/intolerances/sensitivities been tested? ☐ Yes ☐ No If yes, date of testing: _____

How have you been tested? (blood, skin, elimination diet, etc.) ☐ Yes ☐ No

If yes, what was your method of testing? _____

Rate your quality of digestion (10=healthy) Low 1 2 3 4 5 6 7 8 9 10 High

Check any of the following nutritional concerns you have:

☐ Vitamin or mineral deficiency ☐ Chewing/swallowing problems/thirst ☐ Elevated blood glucose ☐ Elevated cholesterol or lipids

☐ Digestive/GI distress ☐ Skin irritation ☐ Other? _____

What does a typical day of eating look like for you?

Morning: _____ Midday: _____

Evening: _____ How much water do you drink in a day (i.e. 40-60 ounces)? _____

Do you have any personal barriers to eating well? ☐ Yes ☐ No

If yes, please describe (access to fresh food, financial constraints, lack of knowledge, busy life/stress, family members, health/medical condition)

_____

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HEALTH & WELLNESS HISTORY

Are you currently being treated for any diagnosed medical or health conditions? ☐ Yes ☐ No

If yes, please explain: _____

Are you currently taking any prescription medications? ☐ Yes ☐ No

If yes, please list (name and dosage) _____

Are you currently taking any supplements? ☐ Yes ☐ No

If yes, please list (name and dosage) _____

Are you currently taking any medicinal herbs? ☐ Yes ☐ No

If yes, please list (name and dosage) _____

Have you ever used a food plan therapeutically? ☐ Yes ☐ No

If yes, please describe: _____

Please list any other nutritionally relevant health history (i.e. surgery, GI disorder, disordered eating)

_____

PHYSICAL STATUS

☐ Prefer not to answer Current Weight: _____ Lowest adult weight: _____ Highest adult weight: _____

Height: _____

Have you experienced any weight changes (gain or loss) in the past 12 months? ☐ Yes ☐ No

Were these changes intentional or unintentional? ☐ Yes ☐ No

Do you spend a lot of time thinking about or worrying about your weight? Please describe.

_____

MOVEMENT

Do you engage in movement practices/exercise? ☐ Yes ☐ No

If yes, describe movement _____

If yes, how many average times per week? 1 2 3 4 5 6 7 8 9 10

SLEEP

How many hours of sleep do you average per night? 1 2 3 4 5 6 7 8 9 10

Rate your quality of sleep (10=high) Low 1 2 3 4 5 6 7 8 9 10 High

STRESS & ENERGY

Rate the level of chronic stress in your life (10=high) Low 1 2 3 4 5 6 7 8 9 10 High

What are your practices/activities for managing stress?

_____

_____

_____

Rate the level of energy in your life (10=high) Low 1 2 3 4 5 6 7 8 9 10 High

Rate the level of your emotional wellbeing (10=healthy) Low 1 2 3 4 5 6 7 8 9 10 High

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LIFESTYLE

Do you smoke tobacco? ☐ Yes ☐ No If yes, how much and how often? _____

Do you consume alcohol? ☐ Yes ☐ No If yes, what kind, how much and how often? _____

Do you drink caffeine? ☐ Yes ☐ No If yes, what kind, how much and how often? _____

Do you use any recreational drugs? ☐ Yes ☐ No If yes, what kind, how much and how often? _____

MOTIVATION

What is your primary motivation to make changes to your relationship to food?

_____

How ready, willing and able are you to make changes in your life?

☐ Not Motivated to Change ☐ Considering Changes ☐ Preparing to Make Changes ☐ Actively Making Changes

☐ Sustaining Changes Made

IS THERE ANY OTHER INFORMATION YOU WOULD LIKE TO SHARE WITH YOUR PROVIDER?

_____

_____

_____

_____

_____

Client Signature _____ Date _____

Parent/Guardian Name _____
(please print)

Parent/Guardian Signature _____ Date _____