Ingrid Knight, RD and Associates, Inc.

Nutrition Therapy, Consulting

Nutrition Consultation Questionnaire **Date of Visit: _____**

Name: _____Date of Birth _____ Age____

Occupation: _____

Nutrition therapy includes a variety of factors: medical, social and personal.
Please share as much as you like so that together we may assist you in reaching your goals.

Purpose of Nutrition Consultation

What do you hope to accomplish through our first visit?

_____

What do you hope to accomplish long-term (6 weeks or more)?

_____

_____

Please feel free to share any additional information here:

_____

_____

_____

_____

Family and Living situation
Tell me about your family and family dynamics:

_____

_____

Does anyone in your family have a history of chronic illness including (like an eating disorder, diabetes, heart disease, high cholesterol, high blood pressure)?

_____

- **Office locations in Athens, Cumming, Marietta and Eastman, Georgia**
- **Virtual Video Consulting available to all Georgia and South Carolina residents**
- **Most insurances accepted**

Call: 404-725-0808 (administration)
E-mail: info@ingridknightrd.com
1026 Twelve Oaks Drive, Ste A
Watkinsville, GA 30677
FAX 1-855-449-4606
www.ingridknightrd.com

Weight Information-if this section feels uncomfortable, leave it blank and we can discuss it together
Height: _____ Age: _____ Current wt: _____

Have you **lost** or **gained** weight recently (Circle one) How much? _____Time frame? _____
Do you weigh yourself currently? If yes, how frequently

_____

Dietary History
Tell me about your dieting history (types of diets, amount of weight lost, short/long-term results, etc.)

_____

Eating Patterns
Please list the usual time, foods and amounts eaten.

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

How many meals per week do you eat at a restaurant?

_____
Which restaurants do you normally choose?

_____
How does your meal and snack pattern vary on the weekend vs. during the week?

_____

Do you cook? □ yes □ no Do you like to cook? □ yes □ no
Who does the grocery shopping? Who prepares the food at home?

_____
Do you read food/nutrition labels? □ yes □ no

Do you travel and/or entertain for business? □ yes □ no How often? _____

Do you have any food allergies or personal food avoidances? If yes, please list, with symptoms:

_____

Exercise and Activity
Have you ever had a consistent exercise routine? □ yes □ no Are you following one currently? □ yes □ no
If yes, please describe:

_____

Personal Health & Medical History
Please list/describe any medical diagnoses or procedures I should be aware of.

_____

If applicable, are you currently getting your period?

Please list your **current medications & supplement** dosages:

_____

Please list/describe any mental health concerns I should be aware of (i.e. depression, anxiety, OCD)?

_____

Please share any illicit drug, alcohol, cigarette use.

_____

Sleeping habits (Total and Quality):

_____

Have you ever been advised by your physician to follow a special diet? (i.e. low salt/cholesterol, no sugar, etc) □ yes □ no What changes did you make at that time?

_____

Have you ever worked with a dietitian/nutritionist? □ yes □ no
If yes, what was your experience?

_____

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