YMCA OF THE NORTH

Nutrition First Session Questionnaire

FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

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 Name

_____

Parent or Guardian (if applicable)

_____ _____

Signature Date