Iowa Specialty Hospitals & Clinics
Specializing in You

Nutrition Education Patient Intake Form

Name: _____ Date of Birth: _____

Name you prefer to be called: _____ Todays Date: _____

Lifestyle/Coping Questions:

Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Who else lives in household? _____

Do you work? ☐ Yes ☐ No

Type of work: _____ Work hours: _____

Race: _____ Primary Language: _____

Please list cultural/religious beliefs that may impact your care: _____

Do you ever fast? ☐ No ☐ Yes: Explain _____

Last grade completed: _____ Can you read English? ☐ Yes ☐ No Can you write English? ☐ Yes ☐ No

Do you have any barriers to receiving care? ☐ Housing ☐ Utilities ☐ Food ☐ Transportation ☐ ADLs
☐ Caregiver ☐ Support Network ☐ None of the above ☐ Other _____

Do you have any difficulty with: ☐ Physical difficulty ☐ Seeing ☐ Hearing ☐ Reading ☐ Writing
☐ English as a second language ☐ None of the above ☐ Other _____

How do you prefer to learn? ☐ Written materials ☐ Verbal Discussion ☐ Videos ☐ Other _____

Tobacco Use ☐ No, never ☐ Previously, total years _____ Quit date _____
☐ Yes: Type _____ Amount _____
Interest in quitting? ☐ Yes ☐ No

Alcohol Use ☐ No ☐ Yes: Type _____ Amount _____

Recreational Drug Use ☐ No ☐ Yes: Type _____ Amount _____

Do you experience pain that affects your lifestyle? ☐ No ☐ Yes: Explain _____

How would you rate your overall health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

What time do you wake up _____ What time do you go to sleep _____

Nutrition Information

Have you had any changes in appetite? ☐ No ☐ Yes: Explain _____

Have you had any recent weight loss? ☐ No ☐ Yes: Explain _____

Have you had any recent weight gain? ☐ No ☐ Yes: Explain _____

Current Height: _____ Current Weight: _____ Goal Weight: _____

Who prepares meals at home? ☐ Self ☐ Other: _____

What types of food do you like to enjoy for

Breakfast _____

Lunch _____

Supper _____

Snacks _____

Home meal plan: ☐ I don't follow a specific plan

☐ I don't follow a specific plan but have tried _____

☐ I would like to learn more about these meal plans _____

☐ I follow a meal plan: _____

How frequently do you eat out? ☐ 1-2 times/month ☐ 1-2 times/week ☐ 3-4 times/week ☐ Daily

Favorite restaurants/fast food places _____

Food allergies/restrictions _____

Do you have any spiritual or cultural practices that may affect your eating patterings or the foods you consume, restrict or limit? _____

What is your biggest challenge to eating healthy? _____

_____

How confident are you in making healthy choices? ☐ Not at all ☐ Somewhat ☐ Confident ☐ Very

In the past 12 months, were there times when it was difficult to buy enough groceries? ☐ Yes ☐ No

Do you use any of the following food assistance programs:

☐ WIC ☐ Food Stamps ☐ Meals on Wheels ☐ Food Pantry ☐ Community Meals

Would you like more information about these programs? ☐ Yes ☐ No

Being Active

What physical activity do you do regularly? _____

How often? _____

What, if any, barriers do you have to physical activity? _____

Do you sometimes get chest pain or heaviness and have to stop? ☐ Yes ☐ No

Today's Appointment

What questions do you have today? _____

_____

What would you like to learn about regarding your health and nutrition? _____

_____

What are your health goals? _____

_____

What are two things you need help with to improve your health?

1) _____ 2) _____

Is there anything else you would like your dietitian to know? _____

_____

What best describes how you feel:

☐ I do not believe I have any nutrition/health related complications/problems

☐ I know I have a nutrition/health related complication, but I don't wish to make any changes at this time.

☐ I am thinking about making a lifestyle change to hopefully resolve health/nutrition issues

☐ I am ready to make a lifestyle change to resolve nutrition/health issues

☐ I have made a lifestyle change in the past 6 months towards resolving health/nutrition complications

☐ I have made a lifestyle change to take care of my health and maintained that change for 6 months or more

☐ I made a lifestyle change to take care of my health at first, but have slipped back to my old habits.

Clinical History

YES	NO	Issues – *please provide details*
◯	◯	Do you have a primary care provider? When was your last visit? _____
		Primary Care Provider: _____
◯	◯	Nerve Problems: _____
◯	◯	Kidney Problems: _____
◯	◯	Stomach or Bowel Problems: _____
◯	◯	Impotence Problems: _____
◯	◯	Frequent Infections: _____
◯	◯	Heart Problems: _____
◯	◯	Sleep Problems: _____
◯	◯	Lung/Breathing Problems: _____
◯	◯	High/Low Blood Pressure: _____
◯	◯	Stroke: (please note when) _____
◯	◯	Arthritis: _____
◯	◯	Eye Problems: _____
◯	◯	Foot Problems: _____
◯	◯	Are you pregnant? If so, when are you due? _____
◯	◯	Are you planning to get pregnant? _____
◯	◯	Did you have any complications during previous pregnancies? _____