

Nutrition Consultation Form

CLIENT INFORMATION:

Name: _____ Date: _____

Age: _____ Date of Birth: _____ Height: ____ (feet) ____ (inches)

Current Body Weight: _____ Desired Body Weight: _____

Lowest Body Weight: _____ Year: _____ Highest Body Weight: _____ Year: _____

Major: _____ Year at Bentley: _____

Extra-Curricular Activities / Sports: _____

Physician: _____ Phone: _____

NUTRITION AND FITNESS GOALS:

What are your nutrition and fitness goals?

1. _____
2. _____
3. _____
4. _____
5. _____

What have you tried in the past to achieve your nutrition and fitness goals? This includes any diet or exercise program, supplement use, books, etc...

1. _____
2. _____
3. _____
4. _____
5. _____

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Clinical Dietician

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MEDICAL HISTORY AND MEDICATIONS:

Please list any relevant past medical history and current medications:

I.e. food allergies/intolerances, high cholesterol, diabetes, heart disease, ADHD, hypo/hyperthyroidism, recent surgeries, bowel disease, depression, eating disorders, recent athletic injuries, anemia, etc...

Have you ever been diagnosed with an eating disorder? Yes or No

Have you ever struggled with eating disordered behaviors? i.e restricting food, diet pills, laxatives, binging and or vomiting... Yes or No If yes, please specify behaviors.

Females Only: At what age did you get your first period? _____

Do you get regular periods? Yes or No

When was your last menstrual period? _____ How long did it last? _____

Do you take any Vitamin / Mineral supplements? Yes or No If yes, please list below:

Do you take any type of nutritional supplements (i.e. protein shakes, powders, energy drinks, etc.) Please be very specific and if necessary attach a picture of the label/ingredients.

Are there any foods that you avoid? Yes or No If yes, please list below:

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Are you a Vegetarian? Yes or No If yes, please circle which foods you **DO NOT** eat:
chicken fish dairy eggs red meat

On average, how many days a week do you consume alcoholic beverages?

On average, how many alcoholic drinks do you consume at one time?

What types of alcohol do you consume?

Beer _____

Wine _____

Liquor _____

Other _____

On average, how many caffeinated beverages do you consume per day?

What types of caffeinated beverages do you consume?

I.e. energy drinks, coffee, tea, soda, etc.

Do you smoke (tobacco products)? Yes or No If yes, how many cigarettes per day?

On average, about how many hours do you sleep: Weeknights _____ Weekends _____

Are you stressed? Yes or No If yes, how stressed are you? Please circle

1 2 3 4 5

Not at all

A little

Moderate

Very

Extremely

How do you manage your stress?

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Have you seen a counselor / therapist in the past, or are you working with someone presently?

EXERCISE:

Are you currently on an exercise program? Yes or No

If so, what specifically are you doing each day?

Sunday: _____

Monday: _____

Tuesday: _____

Wednesday: _____

Thursday: _____

Friday: _____

Saturday: _____

Are you currently working with a Trainer or Coach? Yes or No If yes, who and when?

Have you ever played a sport? Yes or No If yes, which sport(s), when, and how long?

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NUTRITION LOG:

Please list out what a typical day of eating looks like for you. Please be very specific, including times, portion sizes, and brands.

I.e. 1 cup of Tropicana orange juice, 6 ounces Non Fat Dannon Yogurt, etc...

Breakfast: Time: _____

Item(s): _____

Morning Snack: Time: _____

Item(s): _____

Lunch: Time: _____

Item(s): _____

Afternoon Snack: Time: _____

Item(s): _____

Dinner: Time: _____

Item(s): _____

Snack/Dessert: Time: _____

Item(s): _____

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Exercise: _____

Do you live on campus? _____

If Yes, what do you have in your dorm or apartment to store and cook food? (i.e mini fridge, microwave, stove, etc.)

Do you have a meal plan? _____

Do you prepare your own meals? _____

Do you have the ability to grocery shop? _____

Do you have any concerns fitting in meals/snacks based on your current schedule? Yes or No
If yes, please explain.

Please list any additional information you feel would be helpful for me to know.

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