

**Sonoma State University  
Student Health Center**

**Nutrition Consultation**

Name \_\_\_\_\_ DOB \_\_\_\_\_ Today's Date \_\_\_\_\_

Nutrition concerns you would like to discuss \_\_\_\_\_

\_\_\_\_\_ Desired Weight? \_\_\_\_\_

Recent weight change? (circle) Gain Loss How much & how fast? \_\_\_\_\_

Which meals do you most often skip? (circle) breakfast lunch dinner

How often do you skip meals? (circle) never seldom often

Number of snacks eaten/day \_\_\_\_\_ Type of snacks \_\_\_\_\_

List servings of each beverage consumed /day: water \_\_\_\_\_ milk \_\_\_\_\_ coffee \_\_\_\_\_ tea \_\_\_\_\_

Caffeine drinks (i.e. Rockstar, Red Bull etc.) \_\_\_\_\_ soda/punch/fruit drink \_\_\_\_\_

100% fruit juice \_\_\_\_\_ other \_\_\_\_\_

Food Allergies \_\_\_\_\_ Symptoms \_\_\_\_\_

List all medications taken \_\_\_\_\_

List all vitamins and minerals taken \_\_\_\_\_

List all supplements and herbs taken \_\_\_\_\_

Hours spent: sleeping/night \_\_\_\_\_ working/week \_\_\_\_\_ type of work \_\_\_\_\_

Hours of exercise/week: \_\_\_\_\_ Types of exercise \_\_\_\_\_

Housing situation: \_\_\_\_\_ Who prepares your meals? \_\_\_\_\_

Meals eaten out/week: \_\_\_\_\_ Where? \_\_\_\_\_

Do you have difficulty with? (circle) diarrhea constipation low energy other

If yes please specify \_\_\_\_\_

(OVER)

List any special diet you are currently following \_\_\_\_\_

Family history: (circle) heart disease high cholesterol high blood pressure diabetes  
osteoporosis Please specify relationship & age at dx \_\_\_\_\_

Previous cholesterol test? If yes, what was the result and when? \_\_\_\_\_

Previous blood pressure check? If yes, what was the reading? \_\_\_\_\_

Do you smoke cigarettes? If yes, how many/day? \_\_\_\_\_

How many servings of alcohol do you consume per week? \_\_\_\_\_

If weight is a concern, at what age did it become an issue? \_\_\_\_\_

What diets and diet programs have you tried? What were the results? \_\_\_\_\_

What was the most you've weighed as an adult? \_\_\_\_\_ When? \_\_\_\_\_

What was the least you've weighed as an adult? \_\_\_\_\_ When? \_\_\_\_\_

Are any immediate family members overweight? (circle) yes no

If yes, who? \_\_\_\_\_

Have you ever been diagnosed with an eating disorder? (circle) yes no

If yes, please elaborate \_\_\_\_\_

What do you see as possible obstacles to getting to your desired weight? \_\_\_\_\_

**For women only:**

Has your menstrual cycle ever been irregular? (circle) yes no

If yes, please specify (i.e. weeks between periods) \_\_\_\_\_

Are you currently on oral contraceptives? (circle) yes no

If yes, name of med? \_\_\_\_\_