HANSEN
HEALTH SOLUTIONS

Nutrition Evaluation

Patient Name _____ Birthdate ____/____/____ M / F

What goals do you have pertaining to your nutrition?
◇ I want to lose weight
◇ I want to maintain current weight
◇ I want to gain weight/gain muscle
◇ I want to make sure that I am eating what my body needs to maintain optimal health
◇ I have a health condition and improving my nutrition will help me overcome it
◇ I want to prepare for pregnancy and/or influence my family for the best
◇ I am currently pregnant OR have recently given birth and want to "refill the tank" while I breastfeed
◇ Other: _____

Have you utilized specific diets in the past? ◇YES ◇NO
If yes, please list the diet type and tell me if it seemed to be effective or not.

Diet (Atkins, Paleo, Vegan, Vegetarian, etc…)	Effective	Not Effective
_____	◇	◇
_____	◇	◇
_____	◇	◇

Also, if you have utilized specific diets in the past, please list out what you think made them more or less effective (did you have an accountability partner, did you work a job then that gave you more time to prepare foods by hand, did you lose motivation because you weren't reaching your goals?)

_____
_____
_____

Do you have any known or suspected food intolerances or allergies? If so, list them and the reaction you have to them. If you have more than there is space for, add them to the back of the last page. ◇ See back page

Food _____ Response _____
Food _____ Response _____
Food _____ Response _____
Food _____ Response _____
Food _____ Response _____
Food _____ Response _____

Specific foods that you don't like/will not eat:

_____
_____
_____

Foods that you like a lot/enjoy eating/crave:

_____
_____
_____

Tell me about your eating situation.
◇ I am single and eat foods that I prepare (most of the time) from home
◇ I am single and busy, so I eat out a lot
◇ I am married and my spouse and I do our best to make homemade meals happen
◇ I am married and we are both busy, so we typically eat out a lot
◇ I have a small family (spouse/no spouse, 1-2 children)
◇ I have a larger family (spouse/no spouse, 3+ children)

Tell me about your skill level in the kitchen.
◇ I love to cook/prepare food
◇ I don't like to cook/prepare food
◇ I never learned how and don't have desire/time
◇ I learned but don't have time
◇ I do cook/prepare foods sometimes, but it's infrequent
◇ I don't have time to get groceries, so it doesn't happen

Do you feel like you have an emotional relationship with food? ◇YES ◇NO
If yes, explain (do you stress you won't have the opportunity to eat something before someone else in your family finishes it, do you eat more when you are stressed, do you eat less when you are stressed, etc.):
_____
_____

On average, what would you say you currently spend on food weekly/monthly? $_____/week $_____/month
◇ I buy everything conventional ◇ I buy some things organic/some things conventional
◇ I buy mostly organic/pastured/grass fed/wild caught/the whole shebang

Do you exercise? ◇YES ◇NO
If yes: I work out _____ days per week. On average I work out for _____ minutes each day.
◇ I typically do weight-bearing exercises ◇ I typically do cardio ◇ I mix cardio and weight-bearing exercises

What is your current weight? _____ lbs Height? ___ft ___ in What is your ideal weight? _____ lbs

What stressors do you have in your life right now?
◇ I have a very demanding job
◇ I'm looking for a job / am unemployed currently
◇ I lost a loved one recently (how recent? _____)
◇ I recently got married / got divorced (circle one)
◇ OTHER: _____

Check the meals that you consistently have and write the time down that you generally have them:
Time
◇ Breakfast _____am/pm
◇ Lunch _____am/pm
◇ Dinner _____am/pm
◇ 1st Snack _____am/pm ◇ 2nd Snack _____am/pm ◇ 3rd Snack _____am/pm
◇ I eat when I can, I do NOT have a set schedule

Have you ever had any type of eating disorder? ◇YES ◇NO If yes,
_____ For how long were you challenged by this?
_____ ◇ Current/On occasion
When eating out, which restaurants do you prefer?
_____
_____

Medications that you are currently taking:

Name	Length of time used	What for	Dosage	Well tolerated
_____	_____	_____	_____	Y / N
_____	_____	_____	_____	Y / N
_____	_____	_____	_____	Y / N

◇YES ◇NO I eat packaged/boxed foods
◇YES ◇NO I drink pop/soda
◇YES ◇NO I do not drink water daily
◇YES ◇NO I eat white flour, rice, bread, and other grains
◇YES ◇NO I do not eat vegetables daily.
◇YES ◇NO I do use artificial sweeteners and food enhancers (aspartame, Splenda, MSG, Nutrasweet)
◇YES ◇NO I eat fried foods
◇YES ◇NO I use canola oil, vegetable oil, or margarine
◇YES ◇NO I consume alcohol
◇YES ◇NO I feel a lack of energy and/or stamina
◇YES ◇NO I have trouble waking up and starting my day
◇YES ◇NO I feel drowsy during the day
◇YES ◇NO I suffer from skin issues (dermatitis, dry skin, eczema, psoriasis)
◇YES ◇NO I have sinus issues, asthma, allergies (including rashes, hives, etc.)
◇YES ◇NO I have difficulty falling asleep / staying asleep
◇YES ◇NO I have irregular blood pressure readings, high cholesterol, circulatory problems, slow wound healing
◇YES ◇NO I have been diagnosed with one or multiple of the following: obesity, diabetes, high blood pressure, high cholesterol
◇YES ◇NO I currently have or have had cancer in the past
◇YES ◇NO When colds/the flu goes around, I usually get sick
◇YES ◇NO I have joint pain or muscle aches
◇YES ◇NO I get headaches or migraines
◇YES ◇NO I have chronic pain including fibromyalgia or arthritis
◇YES ◇NO I have digestive concerns (bloating, gas, nausea, excessive body odor)
◇YES ◇NO I have diarrhea
◇YES ◇NO I get constipated (less than one bowel movement a day/hard time passing stools)
◇YES ◇NO I get excessive burping and/or heartburn
◇YES ◇NO I retain water or feel “swollen”

LADIES
◇YES ◇NO I took or currently take hormonal contraceptives or synthetic estrogen medications
◇YES ◇NO I have had difficulty conceiving or experienced miscarriages

◇YES ◇NO I have PMS (breast tenderness, water retention, mood changes, discomfort, pain)
◇YES ◇NO I have vaginal infections, urinary tract infections, rectal itching or vaginal itching

GENTLEMEN
◇YES ◇NO I have pain or difficulty with urination
◇YES ◇NO I have had difficulties with fertility

____ Average happiness in the past month (1-10)

____ Average stress level (1-10) in the past month

____ Average productivity (1-10) in the past month

____ Average sustained energy level in the past month (1-10)

____ Average *libido in the past month (1-10) (*sex drive)

____ Average # of cups of water per day in the past month

____ Average # of bowel movements per day over the past month

____ # of days exercised in the past month

____ # of days of relaxation exercises (stretching, yoga, meditation, massage)

____ Average hours spent outside per day in the past month

____ Average hours of sleep per night over the past month

____ # of sick days in the past month

____ # of active prescriptions over the past month - Please list:

____ # of medical visits in the past month

____ # of medical procedures in the past month - Details:

____ Average pain level (1-10) in the past month?

____ Pain level now (1-10)?

Typically your pain ranges from (1-10): ____ to ____

Measurements:

Neck

Chest

Waist

Hips

Right Arm

Right Forearm

Left Arm

Left Forearm

Right Leg

Right Lower Leg

Left Leg

Left Lower Leg