

## Dietary / Nutritional History

Known allergies to food?

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Suspected allergies to food?

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Food cravings?

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I feel my weight is?                      Too Low \_\_\_\_\_ Too High \_\_\_\_\_ Just right \_\_\_\_\_

Have you been on any special diets currently? \_\_\_\_\_

Current Foods I Eat (place a check mark in appropriate column)

Foods / Beverages	Daily	3-5 x/week	1-2 x/week	Never	Used to
Fresh Vegetables					
Fresh Fruits					
Meats/Poultry					
Whole grains					
Legumes					
Bread-white					
Bread-whole grain					
Pasta					
Nuts and seeds					
Cookies/cakes					
Candy					
Milk					
Cheese					
Yogurt					
Ice Cream					
Salty Foods					
Chocolate					
Caffeine (soda/tea)					
Soda					
Soy products /milk					

How much water do you drink every day? \_\_\_\_\_

How much fruit juice do you drink daily? \_\_\_\_\_

Please list a meal history on the back of this page, by either, listing everything you eat for 3 days (preferred) or write what you would eat in a “typical” day.

