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 ? _____

What are possible obstacles to your desired weight? _____

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

Food Allergies _____ Symptoms _____

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

Any diets you have tried_____Results? _____

Current diet plan_____

Meals eaten out/week: _____ Where? _____

Housing situation: _____ Who prepares your meals? _____

Do you skip meals? (circle) none 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 drink/day: water____ milk____ coffee____ tea____juice____alcohol_____

Caffeine drinks (i.e. Rockstar, Red Bull etc.) _____ soda/punch/fruit drink_____

Hours spent: sleeping/night _____ working/week _____ type of work_____

Hours of exercise/week: _____ Types of exercise _____

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

If yes please specify _____

For women only:
Has your menstrual cycle ever been irregular? (circle) yes no