



TOTAL HEALTH CONCEPTS, LLC
(703) 255-7012 / FAX (703) 255-6171

Nutrition, Fitness, and Psychotherapy Professional Services

Please Print Clearly

Nutrition Assessment Form

Date ____/____/____

Last Name _____ First Name _____ Initial _____
Address: _____ State _____ Zip _____
Home Phone: _____ Cell: _____ Work: _____
Email Address: _____

Date of Birth: _____ Age: _____ Sex: M/F Height: _____ Weight: _____
Occupation: _____
Marital Status: S M D W Name of Spouse: _____ Years Married: _____
Length of previous marriages: _____

| Children Names | Age | Sex | Any physical conditions or concerns? |
|----------------|-------|-------|--------------------------------------|
| _____ | _____ | M / F | _____ |
| _____ | _____ | M / F | _____ |
| _____ | _____ | M / F | _____ |
| _____ | _____ | M / F | _____ |

Please fill in the names and phone numbers of the professionals from whom you are currently receiving treatment

| | |
|-------------------------|--------|
| Physician: | Phone: |
| _____ | _____ |
| Psychiatrist: | Phone: |
| _____ | _____ |
| Therapist/Psychologist: | Phone: |
| _____ | _____ |
| Nutritionist: | Phone: |
| _____ | _____ |
| Other: | Phone: |
| _____ | _____ |

Who referred you to Total Health Concepts? _____

Medical Diagnosis/ Primary Concerns or Problems _____

This comprehensive assessment provides us with information that assists us in helping clients with a variety of health issues. Please fill out the sections that apply to your treatment. If you have difficulty or feel uncomfortable filling out any sections, leave them blank and your counselor/therapist will review them with you during your first session.

Personal Health Profile

1) When was your last physical examination? _____

2) Have you / your family ever been treated for or have a history of:

| | You | Parents | Siblings | Extended Family |
|--------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Abdominal cramps | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Alcoholism | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Allergies | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Alzheimer's | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Anemia | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Anorexia | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Anxiety disorders | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Arthritis | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Asthma | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Behavioral problems | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Bipolar Disorder | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Birth defects | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Bronchitis | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Bulimia | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Cancer | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Compulsive overeating | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Congenital defects | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Constipation | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Depression | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Diarrhea | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Dizziness | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Drug abuse | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Edema | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Emotional problems | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Emphysema | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Fibromyalgia | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Gestational diabetes | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart disease | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart attack | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart murmur | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| High blood pressure | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| High cholesterol/triglycerides | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Hypoglycemia | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Liver disease | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Low blood pressure | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Mental retardation | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Migraines | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Nausea | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Obesity (20+ lbs overweight) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Osteoporosis/Osteopenia | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Sexual dysfunction | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Stroke | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Substance Abuse | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Thyroid Problems | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Urinary tract infections | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Varicose veins | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Other chronic or serious health problems/symptoms: _____

Please list any hospitalizations / surgeries / in-patient treatments you have had and your age at the time:

Medications/Supplements

Please list all current medications, dosage, and prescribing physician:

Do you take:

Vitamin/Mineral Supplements: _____

Aspirin/Ibuprofen: _____

Other: _____

Females Only

Are you pregnant? Yes _____ No _____

If so, how many months? _____

Number of pregnancies: _____

Number of miscarriages: _____

Number of abortions: _____

Are you breastfeeding? Yes _____ No _____

Regular menstrual cycle: Yes _____ No _____

Age at which menstruation began: _____

Menstrual cycle irregular/stopped? Yes _____ No _____

At what age? _____

Family History Profile

Family of Origin:

Mother: DOB _____ Age _____

DOD _____ Age _____

General health: Good _____ Fair _____ Poor _____

Cause of death or poor health: _____

Father: DOB _____ Age _____

DOD _____ Age _____

General health: Good _____ Fair _____ Poor _____

Cause of death or poor health: _____

Birth Order: _____ of _____ children

Names and Ages of Siblings: _____

Parented (check those that apply):

_____ Traditional Family _____ Single Parent _____ Adopted/Foster _____ Other

All People Living in Household during childhood:

Your role/behavior in your family during childhood (check all that apply):

_____ Caretaker _____ Controller _____ Pleaser _____ Need to be needed

_____ Passive/Avoider _____ Dependent/Needy _____ Angry/Aggressive

Other: _____

Please list any past family issues or information we should be aware of: _____

Nutritional Profile

Eating Behaviors:

Do you (check all that apply):

- Use food as a reward/to pamper yourself?
- Eat to avoid coping with feelings? (stress, depression, boredom)
- Eat or snack late at night?
- Skip meals?
- Have an inconsistent meal pattern/timing?
- Overeat or eat past fullness?
- Eat at inappropriate times? (watching TV, driving, cooking dinner)
- Eat on the run? (fast food/convenience food/vending machine)
- Eat too fast or rush through meals?
- Binge or overeat without control?
- Purge by vomiting, using laxatives, or other method?
- Avoid major food groups?
- Avoid social eating?
- Fear of weight gain or loss?
- Frequently eat out?
- Crave salty foods?
- Crave sweets? (sugar, candy, chocolate, cookies)
- Crave fats? (butter, margarine, dressings, oils)
- Use artificial sweeteners

Are you currently on a special diet? Please explain: _____

Are you allergic to any of the following?

Gluten Egg Milk All Dairy Nuts Seafood

Other: _____

Are you a vegetarian? Check all that apply:

Exclude Red Meat Exclude Fish/Shellfish Exclude All Dairy
 Exclude Poultry Exclude Eggs

Are there any other food groups you exclude?

Fruit Vegetables Starches Fats

Other: _____

Describe your past diets, include diet pills and/or laxatives, fad diets, liquids: _____

Number of years dieting: _____ Highest adult weight: _____ Lowest adult weight: _____

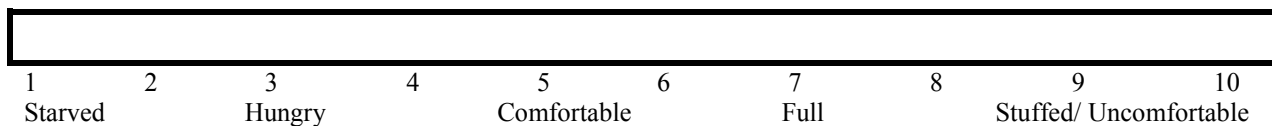
Most stable adult weight: _____

What is your typical daily intake?

| | Time | Activity and feelings (while eating) | Food/Beverages | Hunger scale (before/after) |
|--|------|---|----------------|--------------------------------|
| | | | | |

| | | | | |
|-----------|--|--|--|--|
| Breakfast | | | | |
| Snack | | | | |
| Lunch | | | | |
| Snack | | | | |
| Dinner | | | | |
| Snack | | | | |

Hunger Scale



Estimate how many servings of the following food groups you have daily:

| | 0-2 | 3-5 | 6-8 | 9+ |
|---------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Starches | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Vegetables | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Fruits | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Dairy | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Protein | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Fats & Sweets | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Personal Lifestyle Profile

Educational History:

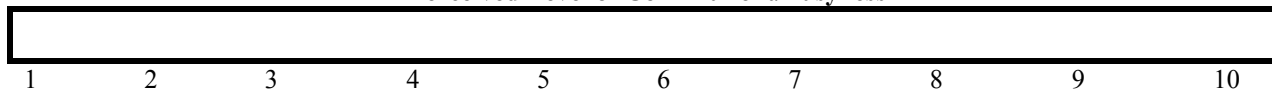
Vocational History/Employment:

Past: _____

Current: _____

Please indicate where your life schedule falls on the scale:

Perceived Level of Commitment/Business



Under Involved Flexible Manageable Tight Schedule Very Tight Schedule

Are you over-functioning, under-functioning, or balanced in the time you spend in the following areas?

| | Over-functioning | Under-functioning | Balanced |
|--------------------|--------------------------|--------------------------|--------------------------|
| Personal Time | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Work/Occupation | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Family Activity | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Social Activity | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Physical Activity | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Spiritual Activity | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Estimate the amount of time spent in each of the following areas (in hours per day or week):

_____ Work/School _____ Spouse _____ Children
 _____ Other Family _____ Social/Friends _____ Hobbies
 _____ Personal Time
 Other: _____

Hobbies/Sports/Recreational Activities:

Cultural/Spiritual/Volunteer Activities:

Legal Problems (arrests, convictions, court ordered treatment):

Sexual History:

_____ Heterosexual _____ Homosexual _____ Bisexual _____ Other
 Currently Active: Yes _____ No _____
 Currently Satisfied: Yes _____ No _____

Stress Profile

| | Yes | No |
|---|--------------------------|--------------------------|
| Do you feel in control of your life? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you feel you have enough personal time? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you make time to relax at least 15 to 30 minutes per day? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you like your job/school? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have friends and enjoy social events? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you find your family situation stressful? <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Is there a history of alcoholism (father/mother)? | <input type="checkbox"/> | <input type="checkbox"/> |
| Is there a history of sexual/physical/emotional abuse? | <input type="checkbox"/> | <input type="checkbox"/> |
| Recent death in family? | <input type="checkbox"/> | <input type="checkbox"/> |

What situations are you dealing with at the present time that may be causing undue stress? Check all that apply:

_____ Work related issues _____ Marriage problems _____ School related issues
 _____ Family issues _____ Time management issues _____ Financial issues

Other: _____

How do you cope with stress? Check all that apply:

- | | | |
|---|--|---|
| <input type="checkbox"/> Talk to Friend/Family Member | <input type="checkbox"/> Read | <input type="checkbox"/> Music |
| <input type="checkbox"/> Pets | <input type="checkbox"/> Physical Activity | <input type="checkbox"/> Prayer/Meditation |
| <input type="checkbox"/> Hobbies | <input type="checkbox"/> Food | <input type="checkbox"/> Alcohol |
| <input type="checkbox"/> Drugs | <input type="checkbox"/> Caffeine | <input type="checkbox"/> Relaxation exercises |
| <input type="checkbox"/> Nothing, I keep it in | | <input type="checkbox"/> Work |

Other: _____

Describe the current stressors or problem situations are you experiencing:

Self-Esteem and Body Image Profile

My internal thoughts about myself are:
 Positive Neutral Negative
Describe: _____

My confidence level is:
 High Neutral Low
Areas where I feel confident: _____
Areas where I do not feel confident: _____

Do your thoughts tend to be all-or-nothing or black-and-white thinking? Explain.

Do you feel good about what others think of you? Explain.

How would you describe your self-worth / value to yourself and others? _____

When you look in the mirror are you happy with what you see? Explain.

Do you feel "fat," if so what specific areas? _____

Behavioral Profile

Your current role/behavior in your life (check all that apply):

_____ Caretaker _____ Controller _____ Pleaser _____ Need to be needed
_____ Passive/Avoider _____ Dependent/Needy _____ Angry/Aggressive

Explain: _____

Smoking History:

Do you smoke? Yes _____ No _____

How many per day _____

How long _____

Are you an ex-smoker? Yes _____ No _____

When quit? _____

Have you ever tried to quit? Yes _____ No _____

By what methods: _____

Sleep Pattern:

How many hours do you sleep at night? _____

Do you have trouble falling asleep at night? How often and why? _____

Do you wake up during the middle of the night? How often and why? _____

Are you tired during the day? How often? _____

Do you sleep/nap during the day? How often and for how long? _____

Drinking Behavior:

Do you drink alcoholic beverages: Yes _____ No _____

What kind: _____

How many per day? _____ Per week? _____

Do you drink caffeinated beverages: Yes _____ No _____

What kind: _____

How many per day? _____ Per week? _____

Do you drink sodas: Yes _____ No _____

What kind: _____

How many per day? _____ Per week? _____

Do you drink water: Yes _____ No _____

How many glasses per day? _____

Summary of Personal Goals

What are your personal health goals? Check all that apply:

- _____ Lose body weight/inches
- _____ Improve nutritional quality and health
- _____ Improved eating behaviors
- _____ Reduce binging/purging
- _____ Reduce compulsive overeating

- _____ Stress management
- _____ Reduce alcohol consumption
- _____ Stop smoking
- _____ Gain lean muscle mass/definition
- _____ Improve posture
- _____ Increase strength and endurance
- _____ Improve cardiovascular fitness
- _____ Develop home exercise program
- _____ Others:

What are your personal nutritional goals? _____

What expectations and goals do you have for your counseling/ nutritional therapy?
