Eileen Pierro, EDN, RDN, LD **Personal and Lifestyle History Form**

Name:_____Occupation:_____

Personal history (Circle your answer)

Have you seen a nutritionist or dietitian?	No	Yes, for what?_____
Do you live alone?	No	Yes, Who?_____
Do you go grocery shopping?	No	Yes If no, who does?_____
Do you cook?	No	Yes If no, who does?_____
Do you have food allergies _____	No	Yes, to
Do you smoke? day?_____	No	Yes, how many a
Do you take street drugs?	No	Yes, what?_____
Do you drink alcoholic drinks?	No	Yes, What?_____
How often do you drink alcohol?	1 2 3 4 5 6 7 days a week	
How often do you exercise?	1 2 3 4 5 6 7 days a week	
How often do you eat out?	1 2 3 4 5 6 7 days a week	
What meals do you eat mostly out?	Breakfast Lunch Dinner	
How long do you exercise?	½ 1 1.5 2 2.5 3 3.5 hours, What type?_____	

Sleep history (circle the letters with your answer)

A. I go to bed usually at the same time and wake up at the same time daily.
B. I follow a regular sleep schedule during weekdays but not weekends.
C. I have no problem falling asleep but wake up in the middle of the night and feel tire in the morning.
D. I don't sleep well at night and take naps in the middle of the day

Stress management (Circle the letter or letters that best describes you)

I recharge by:

a. exercising, socializing cleaning
b. resting, reading, watching TV, driving
c. through meditation, prayer, and spiritual practice

When stressed I crave:

a. chocolate, candy and chips
b. caffeine, meat or spicy foods

c. vegetables, grains and nuts

How would you describe yourself?

a. I'm worry I'm not good enough
b. I'm lazy
c. It's hard to get going
d. I am ambitious
e. I feel worthy
f. I'm high energy
g. I'm active and restful

Relationships:

a. I have a few relationships and I am often lonely
b. I have lots of friends I regularly meet with
c. I have a few close relationships

Family History: Indicate I=Self, M=Mother, F=Father, B=Brother, S=Sister, G=Grandparent

Alcoholism _____	Eating Disorder_____	Kidney Trouble ____
Arthritis _____	Headaches _____	Obesity _____
Ashma _____	Heart Problems _____	Sleep Apnea _____
Depression _____	High Blood Pressure _____	Treatment for Sleep
Diabetes _____	High Blood Sugar _____	Apnea: _____
Digestive Problems _____	High Cholesterol _____	_____

Females only: Age at time of first menses _____ Date of your last menstrual period:_____

Days between periods: _____ Days periods last: _____ Birth Control Pill: Yes or No

Weight and Height History:

Height: _____ Current weight: _____ Desired Weight: _____ Highest weight/ When:_____ Lowest weight/ When: _____