**Intake Assessment Questionnaire**

**Dr. Shrayyef's**
NUTRIGRATIVE WEIGHT MANAGEMENT CENTRE

## PATIENT INFORMATION

| First Name: | Middle Name: | Last Name: |
|---|---|---|
| Date of Birth: _____ /_____ /________ (MM/DD/YYYY) | | Sex: Male Female |
| Health Card Number: | | Expiry Date: ____ /____ /______ |
| Address: | | Appt #: |
| City: | Province: | Postal Code: |
| Tel. Number (Home): | | (Mobile): |
| Email: | | |
| Family Physician: | | Tel. Number: |

## EMERGENCY CONTACT

| Name: | |
|---|---|
| Relationship: | |
| Tel. Number (Home): | (Mobile): |

## SOCIAL HISTORY

1. Do you have private insurance? No Yes

   If yes, who is your provider? ________________________________________________

2. What is your marital status?

   Single Married Common-law Separated Divorced Widowed

3. Do you have any children? No Yes

   If yes, how many children do you have? _______________________________________

4. What is your job status?

   Employed Unemployed Retired Stay-at-home mother/father

5. What is your occupation? _________________________________________________________

6. Do you smoke?

   Non-smoker Current smoker: _____ cigs/day Quit: ____ / ______ (MM/YYYY)
   Amount: _______ packs/day
   Duration:_______ years

7. Do you drink alcohol? No Yes

   If yes, how often do you drink?

   Socially

   Frequently: ________ drinks/week, type: ___________________________

8. Any history of alcohol abuse? No Yes

9. Do you use any recreational or illicit drugs (including marijuana)? No Yes

   If yes, which kind: _______________________________ How often? _____________

**LIFESTYLE HISTORY**

10. On a scale of 1-10, *with 1 being not stressed at all and 10 being very stressed,* what do you rate your current stress level?

    1-3 3-5 5-7 7-9 10

11. How many hours of sleep do you get per night?

    <5 hours 5-7 hours 7-9 hours 9-11 hours

12. Do you have trouble falling asleep? No Yes

13. Do you wake-up frequently at night? No Yes

14. Are you currently physically active? No Yes

    If yes, what are you currently doing for physical activity? (fill in table below)

| What type of physical activity? | How long are you active for? | How often during the week? |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

1. Do you have any health reasons that limit your physical activity? No Yes

   If yes, what is/are the reason(s): ______________________________________________

## Intake Assessment Questionnaire

**MEDICAL HISTORY**

2. Please provide a list of your medical history using the table below.

| Health Conditions | Yes/ No | Time of Diagnosis | Health Conditions | Yes/ No | Time of Diagnosis |
|---|---|---|---|---|---|
| **Diabetes** | Yes<br>No | | **Thyroid Issues** | Yes<br>No | |
| **High Blood Pressure** | Yes<br>No | | **Sleep Apnea** | Yes<br>No | |
| **Dyslipidemia** | Yes<br>No | | **Irritable Bowel Disease (Crohns' & Ulcerative Colitis)** | Yes<br>No | |
| **High Cholesterol** | Yes<br>No | | **Irritable Bowel Syndrome** | Yes<br>No | |
| **Heart Disease** | Yes<br>No | | **Other** (fill in other conditions or surgeries below) | | |
| **Heart Attack** | Yes<br>No | | | | |
| **Angina** | Yes<br>No | | | | |
| **Stroke/TIA** | Yes<br>No | | | | |
| **Fatty Liver** | Yes<br>No | | | | |
| **Anxiety/ Depression** | Yes<br>No | | | | |
| **PCOS** | Yes<br>No | | | | |

15. Are you currently pregnant? No Yes

    If yes, how far along are you? _______ weeks

16. Have you recently given birth? No Yes

    If yes, are you currently breastfeeding? No Yes

17. Have you ever been diagnosed with the following eating disorders?

    Anorexia Nervosa: No Yes

    Bulimia: No Yes

    Binge Eating Disorder: No Yes

## Intake Assessment Questionnaire

19. Do you experience binge eating (eating large amounts of food in a short time)? No Yes

    If yes, how often: ___________________________________________________________

20. Please list all current medications, vitamins and supplements in the table below.

| Name (Medication/Supplement) | Dose | Frequency (How often?) |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

21. Please list any allergies to medications that you have.

    ________________________________________________________________________________
    ________________________________________________________________________________
    ________________________________________________________________________________

**FAMILY HISTORY**

22. Please list your relatives (grandparents, parents, siblings and children) who have any of the following health conditions, as well as their age of onset in the table below.

| Health Condition | Relative(s) | Age of Onset |
|---|---|---|
| **Heart Disease** | | |
| **Diabetes** | | |
| **High Blood Pressure** | | |
| **Angina** | | |
| **Heart Attack** | | |
| **Stroke** | | |
| **Obesity/Weight Issues** | | |
| **Cancer** | | |

| Thyroid Issues | | |
|---|---|---|

**WEIGHT HISTORY**

23. What is your …

Current weight: ____________

Usual weight as an adult: ____________

Heaviest weight (excluding pregnancy): _____________ Age: ______

Lowest weight: _____________ Age: ______

24. What was your weight like at childhood? __________________________________________________

25. What was your weight at puberty? _______________________________________________________

26. When did you start gaining weight? _____________________________________________________

27. Is your weight issue linked to any event or trauma in your life? No Yes

If yes, what was the event/trauma? ______________________________________________

28. Have you previously attempted to lose weight? No Yes

If yes, what have you tried in the past to lose weight? (fill in the table below)

| Method/Program | Year | Duration | Weightloss (kg) | Weight Regain |
|---|---|---|---|---|
| | | | | No Yes<br>Amount: ____ |
| | | | | No Yes<br>Amount: ____ |
| | | | | No Yes<br>Amount: ____ |
| | | | | No Yes<br>Amount: ____ |
| | | | | No Yes<br>Amount: ____ |

## Intake Assessment Questionnaire

**NUTRITION HISTORY**

*This part of the form is for your visit with the Registered Dietitian. The information collected here will provide us with an understanding of your history and needs to provide you with personalized care. Please fill out as accurately as you can, your answers will not be judged.*

30. Have you seen a registered dietitian before? No Yes

    If yes, what was the reason? ___________________________________________________

31. Please list any allergies or intolerances you may have.

    Food allergies: ___________________________________________________________

    Food intolerances: ________________________________________________________

32. How many times do you eat each day? ____________________ times/day

    How many meals do you eat each day? ______________/day

    How many snacks a day do you eat? ________________/day

33. What do you typically eat in a day? (fill in the table below)

| MEAL | What did you eat? | SNACK | What did you eat? |
|---|---|---|---|
| **Breakfast**<br>Time: | | **Morning snack**<br>Time: | |
| **Lunch**<br>Time: | | **Afternoon snack**<br>Time: | |
| **Dinner**<br>Time: | | **Evening snack**<br>Time: | |

34. How much of the following beverages do you drink? (fill in table below)

| Beverages | How many cups a day? | How many times a week? | Beverages | How many cups a day? | How many times a week? |
|---|---|---|---|---|---|
| **Water** | | | **Diet Pop** | | |
| **Coffee** | | | **Juice** | | |
| **Tea** | | | **Milk** | | |

| **Herbal/Decaf Tea** | | | **Other:** | | |
|---|---|---|---|---|---|
| **Regular Pop** | | | | | |

35. Do you eat out from a fast-food restaurant or any other restaurant? No Yes

    If yes, how often do you eat out? _______ time(s)/ week month

    What type of restaurants? ___________________________________________________

36. Who is responsible for the majority of… (i.e. you, spouse, family member, etc.)

    Preparing meals: _____________________________________________________________

    Grocery shopping: ____________________________________________________________

37. Please fill out the following chart about your eating behaviours. (fill in table below)

| **Eating Behaviours** | **Yes** | **No** | **Sometimes** |
|---|---|---|---|
| Do you graze (snack) during the day? | | | |
| Do you snack/eat late at night? | | | |
| Do you eat more than 4 meals from a sit-down or take-out restaurant? | | | |
| Do you struggle with portion control? | | | |
| Do you experience emotional eating? | | | |
| Do you eat quickly? | | | |
| Do you engage in meal prep? | | | |
| Do you track your diet using a food journal or apps? | | | |

**Goals and Readiness Assessment**

38. What are your overall goals for weight-management?

    ______________________________________________________________________

    ______________________________________________________________________

39. What nutrition-related treatment goals do you want to achieve with weight management?

    ______________________________________________________________________

    ______________________________________________________________________

# Intake Assessment Questionnaire

40. What are 3 changes you would like to make to your current lifestyle?

    1. ____________________________________________________________________
    2. ____________________________________________________________________
    3. ____________________________________________________________________

41. On a scale of 1-5, *with 1 being not ready and 5 being very ready,* how ready do you feel to make changes to your lifestyle?

    1 2 3 4 5

42. What do you think is the hardest part about achieving your nutrition and health goals?

    ____________________________________________________________________

    ____________________________________________________________________

43. Are there changes you are not willing to make?

    ____________________________________________________________________