JUPITER MEDICAL CENTER

NUTRITION INITIAL INTAKE CERNER

Name: ______________________________ Date: ______________
Date of Birth: ____________ Height ________ Weight ________ Goal Weight ______________
Weight Changes of last 5 years? ______________

WOMEN OF CHILD BEARING AGE ONLY:

Are you pregnant? No ☐ Yes ☐ If yes, when are you due? ________
# of Pregnancies? _____ # of Live Births? ______ Ages of Children: ______________
Are you planning a pregnancy? No ☐ Yes ☐ When?__________

NUTRITION ASSESSMENT

Have you had previous Diet Instruction? No ☐ Yes ☐ If yes, describe: ______________________
Do you have any diet restrictions? None ☐ Salt ☐ Fat ☐ Protein ☐ Carbs ☐ Potassium ☐ Other __________
Do you eat out? No ☐ Yes ☐ If yes, # times/week ? __________
Type of restaurant (s)? ______________________________
Servings of Fruit /day? _____ Servings of Vegetables/day? _____
# of members in the household? ________ Please list: ______________________
Who does the shopping? ______________ Who does the cooking? ______________
Time of day you are most hungry? Morning ☐ Afternoon ☐ Evening ☐ Late night ☐
Digestive Problems: Food Allergies ☐ please list: ______________________
Nausea/Vomiting ☐ Constipation ☐ Diarrhea ☐ Chewing/swallowing ☐
List all Vitamins and Supplements: ______________________________

____

Give a sample of your meals for a typical day: Indicate portion sizes!

Time: _____ Breakfast ______________________________

____

Time: ______ Lunch ______________________________

____

Time: ______ Dinner ______________________________

____

Time: _____ Dessert ______________________________

Time: _____ Snacks: ______________________________

Time: _____ Snacks: ______________________________

Do you skip meals? No ☐ Yes ☐ If yes, which meal (s) do you skip ______________________
Do you drink caffeine? No ☐ Yes ☐ How many cups/day? _________
How is your food prepared? Fried ☐ Baked ☐ Broiled ☐ Grilled ☐ Gravy /Sauces ☐

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EXERCISE

Do you exercise regularly? No ☐ Yes ☐ Type of exercise? ________________ How often? ________________

Intensity of my work out is: Light ☐ Moderate ☐ Intense ☐

Barriers to exercising? ________________

Hours of Screen time/day? ________________ Hours of Sit time/day? ________________

SOCIAL HISTORY

My stress level: High ☐ Moderate ☐ Low ☐

Currently employed? Employed ☐ Part time ☐ Retired ☐ Unemployed ☐ Student ☐ Occupation________________

Highest Grade completed? ________________

Meal Habits: Hungry all the time ☐ Eat past fullness ☐ Night time eating ☐ Frequent Eating ☐

Eat quickly ☐ # min to finish a meal? ________ Sneaking food/hiding food ☐ Binging ☐ Purging ☐

Hunger symptoms? ________________

Do you have any problems with Teeth ☐ Mouth ☐ Throat ☐ Please explain: ________________

____

Eating Triggers? Stress ☐ Emotions ☐ Sight of food ☐ Smells ☐ Social Situations ☐ Rewards ☐

In the last 12 months ,did you eat less food than you felt you should because there wasn't enough money or food? Always ☐ Sometimes ☐ Never ☐

Do you have any cultural/religious practices or beliefs that influence your medical care? No ☐ Yes ☐

Please explain ________________

MEDICAL CONDITIONS/PROBLEMS

Please check all that apply:

Heart Disease ☐ High Blood Pressure ☐ High Cholesterol ☐ High Triglycericles ☐ Kidney disease ☐

Anxiety ☐ Depression ☐ GI problems ☐

Do you Smoke: No ☐ Yes ☐ # years ______ # packs of cigarettes ________

Do you drink alcohol? No ☐ Yes ☐ Type & amount of alcohol? ________________ How many drinks/week? ______

LEARNING NEEDS

My memory is: Good ☐ Fair ☐ Poor ☐

How do you learn best: Listening ☐ Reading ☐ Observing ☐ Doing ☐ On Computer ☐ Other ________________

Which describes how you feel about learning: Excited ☐ Ready to start ☐ Thinking about it ☐ Not ready ☐

Need Assistance with: Visual Impairment ☐ Hearing ☐ Reading ☐ Physical Limitation ________________

What language do you speak/write most often? ________________

For Office Use Only:

Numeracy and Health Literacy Comments: ________________

____

____

 Form #JMC0192p2 Rev 7/12, 10/13, 12/14, 5/16, 5/17, 9/18

Patient Name: ______________________________ Date: __________

Medication Allergies: ______________________________

Not Taking Any Medications ☐

MEDICATION LIST

LIST ALL MEDICATIONS YOU ARE TAKING INCLUDING OVER-THE-COUNTER AND HERBAL MEDICATIONS			
Name of Medication	**Dose**	**How is it taken? Pill or injection**	**How often is it taken**