ESP DIETITIAN
Counselling & Consulting

Fax 204-691-3964 or email espdietitianccs@yahoo.com

DIET HISTORY FORM

What is the reason for your visit? _____

Have you ever visited a registered dietitian or nutritionist? ☐ Yes ☐ No

When? _____

What was done at the time? _____

_____

Have you ever been on a special diet before? ☐ Yes ☐ No

If so, what type of diet? _____

For how long? _____

What are **your expectations** from this session or sessions? List in order of importance:

1. _____
2. _____
3. _____

Spouse name: _____

Live with? _____

Pets? _____

Children in home? _____

Ages? _____

Daily habits? ☐ Smoke #____/day ☐ Alcohol #____/week ☐ Hours of sleep ____/night

Food Allergies? _____

Food Preferences/dislikes _____

_____

Food Preferences/dislikes of family members: _____

_____

Who shops? _____

Who cooks? _____

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List regular food pattern:

Week day: ☐ Breakfast ☐ AM snack ☐ Lunch ☐ AM snack ☐ Supper ☐ PM snack

Weekend: ☐ Breakfast ☐ AM snack ☐ Lunch ☐ AM snack ☐ Supper ☐ PM snack

Restaurant meals? ☐ Breakfast- Times per week___ ☐ AM snack- Times per week___

☐ Lunch - Times per week___ ☐ AM snack- Times per week___

☐ Supper- Times per week___ ☐ PM snack- Times per week___

Name of restaurants: _____

Difficulties with purchasing food? ☐ Yes ☐ No

If so, list why: _____

Psychology of eating:

☐ Relate food to being a reward
☐ Emotional eater
☐ Avoid food when stressed
☐ Omit meals
☐ other_____
☐ Relate some foods to happy times
☐ Have "feel better foods"
☐ Eat more when stressed
☐ Binge eat

How important is it to change your current diet to achieve your goal?

☐ Not important ☐ Mildly important ☐ Important ☐ Very important ☐ Is my focus no matter what

How confident are you in achieving your goal?

☐ Not confident ☐ Mildly confident ☐ Confident ☐ Very confident ☐ Always achieve my goals