Eating Habits: (Check all that apply)

1. How many meals do you eat each day?_____
2. Do you eat very fast or very slow?_____
3. Do you snack between meals?_____on what?_____
4. How often do you skip meals?_____
5. What beverages do you drink?_____

Medical History:

1. Has your doctor restricted you from doing exercise? ☐ Y ☐ N
   If yes, why?_____
2. Are you presently being treated for any medical problems? ☐ Y ☐ N
   If yes, what?_____
3. Are you on any prescription medication? ☐ Y ☐ N
   If yes, what medicine? _____
4. Are you following any special diet? ☐ Y ☐ N
   If yes, what specific food restrictions?_____
5. Are you presently trying to quit smoking or make another big change in your life?
   ☐ Y ☐ N If yes, please explain:_____

PLEASE DO NOT WRITE IN THIS BOX - OFFICE USE ONLY Weight:_____Date:_____

ASSESSMENT:_____

_____

_____

_____

_____

_____

_____

_____

RD Signature:_____Date:_____ Time:_____