d.b.a. Healthy Pursuit Medical Center S.E.I.

Name _____ **Date** _____ **Acct#** _____

GOALS AND READINESS ASSESSMENT

I would like to receive nutrition counseling today because…

When (age) did your weight change to a point of concern? How did it begin?

Are there triggers which to place on the reason for weight change?

If I could change three things about my health and nutritional habits, they would be…

1.

2.

3.

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The biggest challenge(s) to reaching my nutrition goals is/are:

_____

_____

_____

_____

In the past, I have tried the following techniques, diets, behaviors, etc. to reach my nutrition goals…

_____

_____

_____

_____

On a scale of 1 (not willing/not able) to 4 (very willing/able), please indicate your readiness/willingness to:

To reach optimal health, how willing are you to. . .	**1**	**2**	**3**	**4**
Modify diet				
Engage in regular exercise/physical activities				
Incorporate relaxation techniques into your life				
Modify lifestyle (recreation, sleep, stress. . .)				
Follow up periodically for nutrition counseling				
Keep a food diary to track progress				
Learn healthy habits and put them into practice				

What is your best learning style (read, hands on, video, hearing)?

_____

_____

_____

Would you rather have handouts to take home or websites to visit via internet?

_____

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Name _____ **Date** _____ **Acct#** _____

Please list ALL prescriptions, supplements and over the counter medication taken on a regular basis.

Medication Supplement	Dose	Frequency	Start Date Stop Date	Reason
EX: One A Day Vitamin	1200 mg	Daily	08/22/2001 Current	Supplement diet

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Name _____ **Date** _____ **Acct#** _____

Rate each of the following symptoms based upon your typical health profile for the past 30 days.

1 = no trouble at all

10 = daily occurrence

Headache _____
Faintness _____
Dizzy _____
Insomnia _____

Watery eyes _____
Itchy eyes _____
Swollen eyes _____

Acne _____
Hair loss _____
Hives, rash _____
Dry skin _____

Cough _____
Difficulty:
Swallowing _____
Chewing _____
Breathing _____

Nausea _____
Vomiting _____
Diarrhea _____
Constipation _____
Bloating _____
Heartburn _____

Pain in muscles _____
Feeling tired/weak _____

Weight loss _____
Weight gain _____
Food craving _____
Binge eating _____
Binge drinking _____

Mood swings _____
Anxiety _____
Anger/Aggression _____
Depression _____

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Any other concerns not listed:

_____

_____

_____

Does anything limit your physical activity?

_____

_____

_____

Rate the following stressors: 1(none) 10(high)

Work ____

School ____

Family ____

Social ____

Finance____

Other ____

What helps you unwind?

_____

_____

_____

Daily hours of sleep _____

Smoke ____ If yes, how many packs per day _____

Alcohol ____ If yes, how many drinks per day _____

Highest weight and age (exclude any pregnancy weights) _____ Lowest weight and age _____

Signature _____ Date _____