



UNIVERSITY HEALTH SERVICES (UHS)
NUTRITION CLINIC HISTORY FORM

Date Print Name (Last, First, Middle) PSU ID Number
Local Address Street City State Zip code
Permanent Address Street City State Zip code
Local Phone Work Phone May we leave a Message?

Email address (you will be contacted by email unless you specify otherwise)

Age Birth Date Gender Male Female

PSU Major University Status: FR SO JR SR GR Fac./Staff Other

Occupation (if not full-time student)

Living Situation (check all that apply): Alone Partner Apartment Roommate(s) Parents
Room in a House Spouse Dormitory
Other: (specify)

Referring Person/Agency:

\* University Health Services Clinician Faculty/RA/ROTC Returning
\* CAPS Relative/Student/Friend Website
Personal Physician/Psychologist/ Other Healthcare Professional Self Other: (specify)

\*Please specify name of referring person(s):

Times available for counseling

INFORMED CONSENT

I understand that the Nutrition Clinic is a training clinic and that counseling can be provided by trained nutrition students under a Registered Dietitian's supervision.

I understand that all relationships with the counselors and Nutrition Clinic staff are considered confidential and that personal records or information will not be released to any person or agency without my written consent except for reports to referral agencies and for students to University Health Services medical records. I understand that concerns about suicide, homicide, or child abuse may place limitations on confidentiality.

I understand that I am free to correspond with nutrition clinic staff via email, but that email is not a secure means of communication.

In keeping with the University's support of research activities, I understand that data and counseling information may be used for research purposes, but that no personal identifying information will be revealed without my written consent. I also understand that no research procedure will be performed which represents a risk to me or adversely affects the services provided without advance written agreement to participate.

I understand that I will be charged a fee of \$20.00 if I fail to keep an appointment without notifying the clinic staff 24 hours prior to my scheduled appointment. In addition, if I cancel more than one appointment within a semester, my involvement with the Nutrition Clinic may be terminated.

I have read the above statements, have had an opportunity to ask questions, and give my consent to receive services at the Nutrition Clinic. I fully understand that counseling is voluntary and that I may terminate my involvement at any time by notifying my counselor or the Director of the Nutrition Clinic.

Print Name Print Counselor's Name

Signature



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**Medical History**

**Have you ever had any of the following medical problems? (please check and briefly describe):**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Alcohol and other Drug Abuse                | <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Stomach or GI problems       |
| <input type="checkbox"/> Anorexia/Bulimia/Binge Eating Disorder      | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Thyroid disease              |
| <input type="checkbox"/> Cancer                                      | <input type="checkbox"/> High cholesterol    | <input type="checkbox"/> Vision problem (NOT glasses) |
| <input type="checkbox"/> Diabetes                                    | <input type="checkbox"/> High triglycerides  | <input type="checkbox"/> Weight problem               |
| <input type="checkbox"/> Hearing problems                            |  |   |
| <input type="checkbox"/> Food allergies/intolerances (specify) _____ |  |   |
| <input type="checkbox"/> Other: (specify) _____                      |  |   |

**Has anyone in your family had any of the following problems? (please check and list family member)**

- Cancer \_\_\_\_\_
- Diabetes \_\_\_\_\_
- Heart Disease \_\_\_\_\_
- High blood pressure \_\_\_\_\_
- High cholesterol / High triglycerides \_\_\_\_\_
- Stomach or GI problems \_\_\_\_\_
- Weight problems \_\_\_\_\_
- Other \_\_\_\_\_

**Are you currently taking any of the following? (Please specify)**

Medication prescribed by a doctor

Name: \_\_\_\_\_ How often: \_\_\_\_\_

Over the counter medicines, e.g., appetite suppressants, diuretics, laxatives, etc. \_\_\_\_\_

Nutritional supplements (vitamins, minerals, herbal preparations, performance enhancers, calorie, weight gain supplements, diet aides, etc.):

\_\_\_\_\_

Do you drink alcohol? \_\_\_\_\_ If yes, type, amount, and how often? \_\_\_\_\_

Do you smoke cigarettes? \_\_\_\_\_ If yes, how many and how often? \_\_\_\_\_

**Weight History and Dietary History**

Current Height \_\_\_\_\_ Current Weight \_\_\_\_\_ Desired Weight \_\_\_\_\_

What is the most you have weighed since you stopped growing? \_\_\_\_\_ pounds

What is the least you have weighed since you stopped growing? \_\_\_\_\_ pounds

Have you gained or lost weight recently?     YES             NO

If so, please describe your weight change: \_\_\_\_\_



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**How do you perceive you weight now? (Circle your answer):**

EXTREMELY THIN	SOMEWHAT THIN	NORMAL WEIGHT	SOMEWHAT OVERWEIGHT	EXTREMELY OVERWEIGHT
1	2	3	4	5

**How satisfied are you with your current weight? (Circle your answer):**

EXTREMELY SATISFIED	SATISFIED	NEUTRAL	DISSATISFIED	EXTREMELY DISSATISFIED
1	2	3	4	5

**If your concern is related to your weight, please complete the following questions (circle your answer):**

	ALWAYS	USUALLY	OFTEN	SOMETIMES	RARELY	NEVER
I think about dieting	1	2	3	4	5	6
I feel extremely guilty after overeating	1	2	3	4	5	6
I am terrified of gaining weight	1	2	3	4	5	6
I am preoccupied with a desire to be thinner	1	2	3	4	5	6
If I gain a pound, I worry that I will keep gaining	1	2	3	4	5	6

**Have you ever been prescribed a diet by a doctor?**     YES             NO

If yes, what type of diet? \_\_\_\_\_

**If you have dieted in the past, at what age did you begin dieting?** \_\_\_\_\_ Yrs. Old

Which methods have you most frequently used to control your weight?

- |  |  |
|--|--|
| <input type="checkbox"/> Skip meals                      | <input type="checkbox"/> Reduce portions / calories / fats |
| <input type="checkbox"/> Completely fast                 | <input type="checkbox"/> Fad diets                         |
| <input type="checkbox"/> Restrict carbohydrates / sweets | <input type="checkbox"/> Purging                           |
| <input type="checkbox"/> Exercise                        | <input type="checkbox"/> Laxatives                         |
| <input type="checkbox"/> Other specify) _____            |  |



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**Exercise history:**

**Are you a member of a club sport on campus?**     YES             NO

If yes, what club(s)? \_\_\_\_\_

Do you do any of the following forms of exercise regularly? (Please indicate)

	# TIMES/WEEK	# MINS/SESSION
<input type="checkbox"/> Walking (excluding to and from class)	_____	_____
<input type="checkbox"/> Running	_____	_____
<input type="checkbox"/> Cycling (outdoor)	_____	_____
<input type="checkbox"/> Swimming	_____	_____
<input type="checkbox"/> Aerobic classes	_____	_____
<input type="checkbox"/> Weight/strength training	_____	_____
<input type="checkbox"/> Aerobic equipment (eg. Stairmaster)	_____	_____
<input type="checkbox"/> Toning/stretching/yoga/Pilates	_____	_____
<input type="checkbox"/> Other (specify)	_____	_____

**Nutrition concerns:**

**Have you been seen at the Nutrition Clinic before?**     YES     NO, If yes, when? \_\_\_\_\_ Semester \_\_\_\_\_ Year \_\_\_\_\_

**Please state briefly what concerns lead you to come to the clinic at this time:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Have you consulted a health professional (Physician, Nutritionist or Psychologist) about these concerns in the past?**

YES         NO

If so, whom? \_\_\_\_\_ When? \_\_\_\_\_

Briefly describe the situation: \_\_\_\_\_

\_\_\_\_\_

**Please indicate how often you include the following foods in your diet:**

1. Milk, cheese, yogurt: \_\_\_\_\_ servings per day
2. Vegetables and vegetable juices: \_\_\_\_\_ servings per day
3. Fruit and fruit juices: \_\_\_\_\_ servings per day
4. Breads, cereals, grains (pasta, rice, etc.): \_\_\_\_\_ servings per day
5. Meat, fish, poultry, dried peas, beans, lentils, eggs: \_\_\_\_\_ servings per day
6. Fats: oil, butter, margarine, salad dressings: \_\_\_\_\_ servings per day
7. Desserts (cookies, candy, ice cream, etc.): \_\_\_\_\_ servings per day
8. Caffeinated beverages (coffee, tea, etc.): \_\_\_\_\_ servings per day
9. Water: \_\_\_\_\_ servings per day