Name_____ dob_____date_____-

Known allergies to food?

_____

_____

Suspected allergies to food?

_____

_____

Food cravings?

I feel my weight is? Too Low _____ Too High _____ Just right_____

Have you been on any special diets currently? _____

Current Foods I Eat (place a check mark in appropriate column)

Foods / Beverages	**Daily**	**3-5 x/week**	**1-2 x/week**	**Never**	**Used to**
Fresh Vegetables					
Fresh Fruits					
Meats/Poultry					
Whole grains					
Legumes					
Bread-white					
Bread-whole grain					
Pasta					
Nuts and seeds					
Cookies/cakes					
Candy					
Milk					
Cheese					
Yogurt					
Ice Cream					
Salty Foods					
Chocolate					
Caffeine (soda/tea)					
Soda					
Soy products /milk					

How much water do you drink every day? _____

How much fruit juice do you drink daily? _____

Please list a meal history on the back of this page, by either,

A) listing everything you eat for 3 days (preferred) or

B) write what you would eat in a “typical” day. If you would also include time of day, amount of food or drink that would be most helpful. The three days may be in a row or not.