



New Client Questionnaire

Name:

Date:

Gender:

Date of Birth:

What is your primary purpose for meeting with me?

Why is this important to you?

What are your goals?

Short term:

Long term:

What do you hope to accomplish through our visits?

Have you ever worked with a Registered Dietitian/Nutritionist previously? Yes No

If yes, please tell me a little about the experience.

Tell me about your nutrition history regarding: fueling the body, dieting and/or disordered eating history.

Please list and describe any current or past medical diagnoses or procedures:



Please list and describe any mental health concerns I should be aware of:

Are you currently working with a therapist or counselor? Yes No
If no, have you ever worked with a therapist or counselor in the past?

Please answer the following questions:

I feel extremely guilty after overeating?

Always Usually Often Sometimes Rarely Never

I am preoccupied with the desire to be thinner?

Always Usually Often Sometimes Rarely Never

I think that my stomach is too big?

Always Usually Often Sometimes Rarely Never

I feel satisfied with the shape of my body?

Always Usually Often Sometimes Rarely Never

My parents, teachers and/or coaches have expected excellence of me?

Always Usually Often Sometimes Rarely Never

As a child I tried very hard to avoid disappointing my parents, teachers, and/or coaches?

Always Usually Often Sometimes Rarely Never

Are you trying to lose weight now? Yes No

Have you tried to lose weight? Yes No

How many times have you tried to lose weight?

1-2 3-5 More than 5

Thank you for your honest and vulnerability in sharing this information.