Tateishi Nutrition

INITIAL DIETARY ASSESSMENT

☐ Male ☐ Female

Name:_____ Date:_____

Address:_____ Tel. (Res.)_____

_____ (Bus.)_____

Zip Code_____ Fax:_____ (Cell.)_____

Date of Birth:_____ Email:_____

Physician:_____ Referral From:_____

Reason for Referral:_____

Medications Presently Taken:_____

_____

Height:_____ Weight:_____ Length at Present Weight:_____

Weight Description from Childhood to Present_____

_____

Past Diets Tried –  Name/Type?	When?	How Long?	Weight Lost?	Weight Loss Maintained For?

Physical Symptom Survey

Frequency – Indicate #/week, #/month, etc.

Symptom	Day	Week	Month	Never	In Childhood/ Adolescence only
Asthma					
Burping/Belching					
Frequent Colds					
Constant Stuffy/Runny Nose					
Coughing Spells					
Dizziness/Lightheadedness					
Ear Infections					
Eczema/Rashes/Hives					
Excess Throat Mucous					
Fatigue					
Frequent Urination					
Feel Shaky if Hungry					
Gall Bladder Problems					
Gas/Flatulence					
Hayfever					
Headaches/Migraines					
Indigestion					
Insomnia					
Kidney or Bladder Problems					
Liver Problems					
Muscle/Joint Aches/Pain/Soreness					
Nosebleeds					
Shortness of Breath					
Sleepy After Meals					
Stomach Aches/Pains/Cramps					
Stomach Bloating					
Vomiting					
Poor Memory/Difficulty Concentrating					

Bowel Movements: Frequency #_____/day #_____/week _____

Consistency: ☐Formed ☐Watery ☐Loose Unformed ☐Hard Dry Color_____

Please list any food, medication or environmental allergies/sensitivities/intolerances:

_____

_____

Medical History

Please indicate if you have any of the following:

☐Diabetes Mellitus ☐Type 1 ☐ Type 2 Dx. When?_____

☐Hypoglycemia ☐High Blood Pressure ☐Arthritis

☐Heart Disease – explain:_____

☐Crohn's Disease Dx. By:_____When?_____

☐Previous Surgery(ies) for Crohn's Disease?:_____

☐ Spastic/Irritable Bowel Syndrome – explain:_____

☐Chronic Fatigue Syndrome Dx. By:_____ When?_____

☐Fibromyalgia Dx. By:_____ When?_____

☐Connective Tissue Disorder (e.g. Lupus) Dx. When?_____

☐Anxiety/Depression ☐Stress Disorder Dx. When?_____

☐Other:_____

Lifestyle

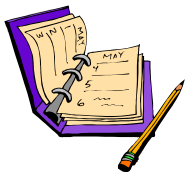
Exercise/Activities – List	How Often Per Week	Minutes of Activty/Session

Family History

Put an X in the column of the family members who have or have had these conditions. If more than one brother or sister has or had these conditions, put two Xs in the column. Treat the "other" column (aunts, uncles, grandparents) the same way.

Condition	Mother	Father	Siblings	Others
Heart Disease				
Obesity				
Diabetes Type 1				
Diabetes Type 2				
High Blood Pressure				
Spastic/Irritable Bowel Syndrome				
Crohn's Disease				
Food Allergies				
Medication Allergies				

Other:_____



Instructions for Food Diary Recording

In order to evaluate your dietary habits and nutrient intake, a 3-day food record is requested. Choose 3 consecutive days, including one weekend day for the most accurate analysis.

Information required on the food diary recording includes:

1. the date;
2. the clock time of food consumption;
3. all foods, beverages and vitamin In order to evaluate your dietary habits and nutrient intake, a 3-day food /mineral supplements consumed.

Please indicate the amounts of all foods and beverages consumed e.g.:

- 1 cup or 8 oz. of cooked, brown rice;
- ½ cup or 4 oz. of 2% milk;
- ¾ cup or 6 oz. of fresh squeezed orange juice
- 3 oz. baked chicken breast (no skin).

Indicate the preparation method used, e.g. fried, broiled, boiled, etc. If the food was fried, indicate what the food was fried in i.e. the brand name of the oil, margarine, butter or non-stick spray and how much was used.

Indicate any extra condiments used e.g.:

- 1 tsp. Benecol Margarine on 1 slice of sourdough rye bread
- 2 tsp. brown sugar on ½ cup of Quaker instant oatmeal, cooked.

For combination dishes, such as casseroles, stews, meat loaves or baked items, please list the ingredients and the number and size of servings.

Turkey Loaf

2 lbs. of ground turkey
½ cup of Ralph's Brand tomato paste
¾ cup dried bread crumbs
1 tsp. dried oregano Yield: 8 – 6 oz. servings

Indicate the name of any vitamin or mineral supplements taken and the amount. Either the empty container or labels should be submitted.

One very important point to remember when recording information, please be as accurate and as honest as possible.