

Name:		Student ID/Z#		Date / /	
Local Address (City, State, Zip Code)				Are you?	
Cell phone # ()		Type of insurance: _____		Active duty service member? ☐ Yes ☐ No	
Birth Date / /		Relationship status:		Veteran of the U.S. Military? ☐ Yes ☐ No	
Sex assigned at birth: ☐ Male ☐ Female ☐ Anything else _____ Preferred name: _____				Dual-enrolled high school student? ☐ Yes ☐ No	
Gender Identity: (check all that apply)				FAU staff or faculty member taking courses through Employee Educational Scholarship Program? ☐ Yes ☐ No	
☐ woman ☐ man ☐ genderqueer ☐ trans woman ☐ trans man ☐ prefer not to say ☐ self identity _____				FAU staff or faculty member taking courses, but not through Employee Educational Scholarship Program? ☐ Yes ☐ No	
What pronouns do you use?					
☐ she/her/hers ☐ he/him/his ☐ they/them/their ☐ Anything else _____					
Ethnicity (please check one): ☐ American Indian/Alaskan Native ☐ White ☐ Hispanic ☐ Asian/Pacific Islander ☐ Black/African American ☐ Prefer not to answer					
PAST MEDICAL HISTORY					
ALLERGIES: (Include drug, food and environmental allergies)					
CURRENT MEDICATIONS: (include contraceptives, supplements, and over-the-counter preparations; include dose and frequency)					
Do you have any medical diagnoses? If yes, please list here:					

☐ General balanced eating ☐ Nutrition education ☐ Desired weight gain ☐ Desired weight loss ☐ Food intolerances ☐ Food allergies ☐ Celiac Disease	☐ Emotional eating ☐ Disordered eating ☐ Anemia ☐ Diabetes or pre-diabetes ☐ High blood pressure ☐ Heartburn ☐ Vegetarian/Vegan	☐ High cholesterol ☐ High triglycerides ☐ Fatigue/low energy ☐ Nausea/Vomiting ☐ Diarrhea/Constipation ☐ Inflammatory Bowel Disease (UC/Crohn's) ☐ Sports Nutrition
--	--	--

1. _____
2. _____
3. _____

☐ Yes

☐ No

Never Rarely Sometimes Often Always

☐ ☐ ☐ ☐ ☐

Do feelings about your weight, body and/or body image contribute to feeling: *(Select all that apply)*?

☐ Hopeless ☐ Overwhelmed ☐ Exhausted ☐ Very Sad ☐ Depressed ☐ None

How would you describe your eating habits?

☐ Good ☐ Fair ☐ Poor

On average, how many meals do you eat per day? _____

Where do you eat the majority of your meals? _____

Do you have any cultural/ethnic/religious affiliations that may have an impact on your nutrition? _____

Are you satisfied with your eating patterns?

☐ Yes ☐ No

Do you ever eat in secret?

☐ Yes ☐ No

Does your weight affect the way you feel about yourself?

☐ Yes ☐ No

Have any members of your family suffered with an eating disorder?

☐ Yes ☐ No

Do you currently suffer with or have you ever suffered in the past with an eating disorder?

☐ Yes ☐ No

For the following statements, please say whether the statement was OFTEN true, SOMETIMES true, or NEVER true for you in the last twelve months:

I was worried whether my food would run out before I got money to buy more.

☐ Often true ☐ Sometimes true ☐ Never true

The food that I bought just didn't last and I didn't have money to get more.

☐ Often true ☐ Sometimes true ☐ Never true

Is there anything else you would like to share with me today? _____

Patient Signature

Date

Provider Signature

Date