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Founding Member Adult Weight Management Practice Group-
Dietetics in Developmental and Psychiatric Disorders Group-
American Dietetics Association
Board Member – Tennessee Dietetics Association

Mailing Address: 6658 Sandwood Circle Harrison, TN 37341

Name: _____ Gender: __ Male ___ Female
Age: _____ Ht: _____ Weight: _____
Daytime phone: _____ Evening phone: _____
Address: _____

Primary Physician: _____ Phone number: _____

Address: _____

What program are you participating in? HeadStart Wellness program Which center? _____

Personal medical history:

<input type="checkbox"/> Elevated cholesterol	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Elevated triglycerides date:	<input type="checkbox"/> Gallstones	<input type="checkbox"/> Sleep apnea
<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Stroke	<input type="checkbox"/> Reflux disease
<input type="checkbox"/> Asthma	<input type="checkbox"/> Obesity	<input type="checkbox"/> Anemia
<input type="checkbox"/> Stomach ulcers/Colitis	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Migraines
<input type="checkbox"/> Chronic constipation	<input type="checkbox"/> Menopause	<input type="checkbox"/> Physical inactivity
<input type="checkbox"/> Smoker	<input type="checkbox"/> Osteoarthritis	<input type="checkbox"/> Other _____

List any surgeries or hospitalizations: _____ Year _____
 _____ Year _____
 _____ Year _____

List **all** medications you are taking (herbs, vitamins, minerals, over-the counter and prescription)

Medications/Herbs/Vitamins	Dose	Frequency	Reason for taking

Name: _____ Family Medical History: _____

	Age	If living		If Deceased		List any blood relatives who have had the following:			
		Health Good Fair Poor		Cause of Death	Death Age		Yes	No	Relationship
Father						Heart Disease			
Mother						Diabetes			
Siblings						High Blood Pressure			
1. M F						Stroke			
2. M F						Cancer			
3. M F						Obesity			
4. M F						Asthma			
						Alcoholism			
						Kidney Disease			

What's your current physical activity level? Active Describe: _____

Inactive Never exercise

Physical Activity Readiness Questionnaire	YES	NO
Has your doctor ever said that you have a heart condition and that you should only do physical activity as recommended by a doctor?		
Do you feel pain in your chest when you do physical activity?		
In the past month, have you had chest pain when you were not doing physical activity?		
Do you lose your balance because of dizziness or do you ever lose consciousness?		
Do you have a bone or joint problem that could be made worse by a change in your physical activity?		
Is your doctor currently prescribing drugs (for example, water pills) for your blood Pressure or heart condition?		
Do you know of any other reason why you should not do physical activity?		

FOOD SCORE SHEET – Check which answer is similar to your usual intake YES NO

I consume at least 2 servings of yogurt, cheese, or cottage cheese each day		
I drink at least one cup of milk each day (soy, nutrish, ... or equivalent)		
I eat at least 5 servings of fruit and vegetables day (1/2 cup = 1 serving)		
I eat at least 3 different varieties of fruits and vegetables.		
I eat more than 6 servings of breads, starches, and cereals each day		
I eat at least 3 starches a day.		
I eat breakfast every morning		
I eat fast food at least 3 times a week.		
I eat 1-2 small desserts each day		
I drink more than 16oz of beverages with added sugar each day		
I eat a protein with each meal		
I eat more than 3 ounces of meat with a meal		
I use butter or margarine at every meal.		
I avoid visible fats on meats		
I only eat high fiber cereal or whole grain bread		
I eat bread with every meal		

	YES	NO
I consume at least one citrus fruit or juice daily		
I eat a dark green or yellow vegetable daily		
I add salt at the table		
I drink at least 16oz of water each day.		
When at home, I only eat at the kitchen or dining room table		
When at work, I eat at my desk.		
I am relaxed and enjoy eating		
I do other things while eating, ie newspaper, TV, internet		
I eat 3 meals a day.		
I eat a fruit for snacks each day		
I take at least 20 minutes to complete my meals		
I do eat seconds during meals		
I use added fats daily: salad dressing, margarine, mayo, oil		
I avoid any fried foods		
I drink >2 alcoholic beverages each day		
I eat at least one serving of beans each day		
I eat without 'guilt'		

Record your intake for one day: Include fluid intake, portion sizes, and ingredients used to season food. The more details you include the better your analysis will show the adequacy of your intake.

Time	Meal	-SAMPLE- Food	Where I eat
<i>Example</i> 6: 30 am 7:00 am	<i>breakfast</i>	<i>Diet coke and glazed doughnut Large coffee with 2 creamers and 2 packets sugar 1 Egg McMuffin 16oz orange juice</i>	<i>home McDonalds- in my car</i>
10:00	snack	6 peanut butter and crackers from vending machine 20 oz diet dr pepper 16oz water	Desk at work
1:00pm 2:00pm 3:00pm	Lunch	Sandwich from home: 1oz turkey, lettuce, tomato, pickle, 2 tbsp mayo, 1 Tbsp mustard, on white bread 1oz bag baked lays 1 large apple with 2 slices American cheese large oatmeal Debbie cake 20oz diet coke 16oz water	Break room Desk desk
4:30pm	snack	20oz regular caffeine free coke king size snicker bar	car
7:00pm	Dinner	3oz BBQ chicken breast baked without skin 1 cup mashed potatoes with skim milk, liquid parkay fat free margarine, salt, pepper, and garlic 1 cup baked apples with 1 Tbsp sugar and 1 tsp cinnamon ½ cup green beans cooked with 1 Tbsp vegetable oil, 1 pinch salt 2 slices white bread 20 oz decaf sweetened tea with sugar substitute	Living room with TV on
8:30pm 9:30pm	Snacks	1 bag buttered microwave popcorn with 20 oz diet coke Yellow cupcake with chocolate icing, homemade 10 oz whole milk	In recliner watching TV In bed reading

ONE DAY FOOD DIARY

Name: _____ Gender: _____ Height: _____ Weight: _____ Age: _____

Time	Meal	Food	Where I eat
	<i>Breakfast</i>		
	Snack		
	Lunch		
	Snack		
	Dinner		
	Snack		

