Caroline Wang
Dietitian/Nutritionist
91, Laval St., Gatineau, QC, J8X 3H4
Tel.: 819 771-8700 • Fax: 819 771-8683

Initial Questionnaire

Date of consultation: ______________________________

Name: ______________________________ Gender: Woman ❑ Man ❑

Date of birth: day: ________ month: ________ year: ____________ Age: ____________

Address: ______________________________

City: ____________ Province: ____________ Postal code: ____________

Telephone: ______________________________

Email: ______________________________

Health plan covering: Dietitian/Nutritionist ❑ Naturopath ❑ None ❑

How did you become aware of this service? ______________________________

____

Reason for consultation: ______________________________

____

____

Professionals seen previously / Exams done: ______________________________

____

____

____

Weight change in recent years: stable ❑ gain ❑ loss ❑

Current weight: ______________________________

Previous weight: ______________________________

Desired weight: ______________________________

Height: ______________________________

Other measures: ______________________________

Appetite change in recent years: stable ❑ gain ❑ loss ❑

____

Stool (number, frequency): ______________________________ formed ❑ not formed ❑

____

Difficulty chewing: no ❑ yes ❑ ______________________________

Difficulty swallowing: no ❑ yes ❑ ______________________________

Reflux: no ❑ yes ❑ ______________________________

Nausea: no ❑ yes ❑ ______________________________

Vomiting: no ❑ yes ❑ ______________________________

Gas: no ❑ yes ❑ ______________________________

Abdominal pain: no ❑ yes ❑ ______________________________

Other symptoms: no ❑ yes ❑ ______________________________

____

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Medical Background

Health problems: ______________________________

____

____

Allergies: ______________________________

____

Intolerances: ______________________________

____

Family history: ______________________________

____

Medications: ______________________________

____

____

Supplements: ______________________________

____

Natural products: ______________________________

____

Social Background

What is your main occupation (type and schedule)? ______________________________

____

Who do you live with? ______________________________

____

Do you have children (number and age)? ______________________________

____

Are you experiencing an excess of stress or hard times? Which ones? ______________________________

____

Who do you get support from during hard times? ______________________________

____

Lifestyles

Physical activity (type, duration, frequency): ______________________________

____

____

Sleep (quality and duration): ______________________________

____

Alcohol (quantity and frequency): ______________________________

Tobacco (quantity and frequency): ______________________________

Drug (quantity and frequency): ______________________________