Date: _____

UCSB STUDENT HEALTH
NUTRITION REGISTRATION

All information received on this form is confidential

(Please Print)

PATIENT INFORMATION		
Last name:	First:	Perm #:
Preferred name/Nickname:		
Referred to nutrition by:		n/a
Who is your (if not applicable, circle n/a):		
Primary care doctor/nurse practitioner?		n/a
Psychiatrist?		n/a
Therapist/Psychologist?		n/a
Other practitioner?		n/a

REASON FOR VISIT/CONCERNS
What health and/or nutrition concerns would you like to focus on during your appointment?
1.
2.
3.

NUTRITION & LIFESTYLE		
ALLERGIES		Allergic Symptoms Experienced
Food(s)		
Supplement(s)/ Medication		
Environmental		
Other:		

NUTRITION HISTORY
Do you have a campus meal plan? ☐Yes ☐No If yes, how many meals/week? If yes, at which Dining Commons do you typically eat?
Are you currently following a particular diet or nutrition plan? ☐Yes ☐No Please describe
Do you avoid any foods or food groups? ☐Yes ☐No If yes, why?

What have you consumed in the past 24 hours? (food & beverages)		
Breakfast Snacks:	Lunch	Dinner
How many meals do you eat each day?	How many snacks do you eat each day?	
How many meals do you buy from a restaurant or fast food per week? ☐0-1 ☐2-3 ☐4-6 ☐ 6+		
Do you drink alcohol? ☐Yes ☐No If yes, how many drinks per week?		
Do you drink caffeinated beverages? ☐Yes ☐No If yes, how many cups per day?		
Have you recently lost or gained weight? ☐Yes ☐No If yes, please describe.		
Do you have or have you had an eating disorder? ☐Yes ☐No If yes, please describe.		
Any further explanation of your diet?		

MEDICATIONS/ SUPPLEMENTS/HERBS/PROTEIN POWDERS, ETC…		
What (ex: fish oil)	**Amount** (1,000 mg)	**Frequency** (1 time/day)

GENERAL LIFESTYLE INFORMATION		
Do you engage in physical activity on a regular basis? Yes ☐ No ☐ If yes, complete the table below		
Activity	**Times/week**	**Duration per time**

Sleep		
Average hours you sleep on weeknights/weekends?		
Trouble falling asleep?☐	Wake up during the night? ☐ Don't feel rested? ☐	
Stress		
Generally, how stressed out do you feel on a daily basis? 1 = no stress, 10 =worst ever		
How do you handle stress? What do you do to relax/have fun?		
Is there any other information that you think might be beneficial for us to know?		

Student Signature _____ Clinician Reviewed _____ Date _____