Nutrition Services

Pepperdine University Student Health Center
Intake Information 2007-2008

Intake Date________ **Semester: Fall Spring Summer**

Name ________________________________ University ID # _______________ Campus Box # ________
Date of Birth ____________ Gender ❑Male ❑Female

Undergraduate
❑ Seaver-Malibu Year: 1 2 3 4 5+ Class of: 2011 2010 2009 2008
❑ GSBM --BS program

Graduate Student
❑ GSBM---Malibu ❑ GSBM---Other location __________________
❑ GSEP---Malibu ❑ GSEP---Other location __________________
❑ Law School ❑ School of Public Policy ❑ Seaver Graduate program

Major: GPA : Current units. enrolled:
Employer: Job hrs/week:
Career plans/direction if known:

Local Address: Street or box # ____
City, Zip ____
Is it OK to send mail to you at this address? Yes No
❑ Residential Hall ❑ On-campus-apts ❑ Off-Campus-university-related apts
❑ Off-Campus-private apts or home ❑ Home of parent(s)

E-mail address:______________________________
Is it ok for us to send email to you at this address? Yes No
Local phone number :_________________________
Is it ok to leave a voice message at this number? Yes No
Cell phone number :__________________________
Is it ok to leave a voice message at this number? Yes No

Permanent Address: ____
Street City State Zip
Is it OK to send mail to you at this address? Yes No
Permanent Phone number __________ Is it ok to leave a voice message at this number? Y N
Contact in Case of Emergency________________________________ Phone_______________________
Relationship____________________________

Background Information/Demographics
Ethnic Origin:
❑ African American ❑ Asian (including Indian subcontinent) ❑ Asian American ❑ Caucasian
❑ Hispanic/Latino/Latina ❑ Native American, Alaska Native ❑ Native Hawaiian, Pacific Islander
❑ Puerto Rican ❑ Multi-racial/Multi Ethnic ❑ Other:___________

International Student: ❑Yes ❑No Country of Origin ____________________

Religion _______________________ How significant to you? not very somewhat very

How did you hear about our nutritional services?
❑ My Pepperdine Nurse
❑ My Pepperdine Counselor
❑ Nutrition presentation at a Sorority/Fraternity meeting
❑ Nutrition presentation in the dorm
❑ Nutrition presentation in the Wave's Cafe
❑ The Graphic
❑ The Link
❑ Other ____

❑ Do you receive any Student Counseling Center services?
❑ Counselor
Name____
❑ Psychiatrists

❑ Do you receive any Student Health Center Services?

Medical History

Height:_________ Weight:________
How long have you been this weight? ________
What is your highest weight since age 14?__________
What is your lowest weight since age 14?___________
Do you utilize the Student Health Center or see an off campus physician for medical concerns:
❑ Health Center ❑ Off campus

Do you have any medical/psychological conditions? ❑ Yes ❑ No
❑ Food Allergies/Intolerances ❑ Iron Deficiency Anemia ❑ Colitis
❑ Irritable Bowel Syndrome ❑ Cancer ❑ Diabetes
❑ Hypoglycemia ❑ High Cholesterol/Triglycerides
❑ Eating Disorder
❑ Drug/Alcohol Abuse

Are you currently taking any medications? ❑ Yes ❑ No
Please list prescribed and/or over the counter (such as aspirin, laxatives, diet pills):
____

Are you currently taking any supplemental vitamins, minerals or herbs?
❑ Vitamins ❑ Minerals ❑ Herbs

Please indicate any medical/psychological conditions you have ever had or presently have by checking the box:
❑ Heart disease ❑ High cholesterol ❑ Diabetes
❑ Depression ❑ Eating Disorder ❑ Food allergies/intolerance
❑ High Blood Pressure ❑ Obesity/overweight ❑ Gastrointestinal problems
❑ Constipation/diarrhea ❑ Alcohol/drug abuse ❑ Other________________

Does anyone in your family have any of the above medical problems? ❑ Yes ❑ No
If yes, which problem?____

For females only:

Do you have irregular periods? ❑ Yes ❑ No
If yes, date of last menstrual period: ________________________
Are you currently taking oral contraceptives or other hormones? ❑ Yes ❑ No

<u>Lifestyle Profile</u>

Do you currently smoke? ❑ Yes ❑ No
Do you consume alcohol regularly (at least once/week)? ❑ Yes ❑ No

Do you currently exercise? ❑ Yes ❑ No
If yes, Type & Frequency: ____

How stressful do you consider your life right now? (circle) 1 2 3 4 5
1 not stressful/5 extremely stressful

How is your food intake affected by stress? (check all that apply)
❑ No effect ❑ Eat more ❑ Eat less
❑ Gastrointestinal problems ❑ Other____________________________________

<u>Nutritional Profile</u>

Have you consulted a nutritionist before? ❑ Yes ❑ No
If yes, for what purpose:____
Please check the statements which describe your eating pattern:
❑ Eat three meals a day ❑ Often skip meals ❑ Snack between meals
❑ Often eat out ❑ Often eat "on the go" ❑ Often eat in car
❑ Follow vegetarian diet ❑ Avoid specific foods ❑ Frequently diet
❑ Currently follow special diet
❑ Use calorie restriction to lose weight
❑ Use other means to lose weight (laxatives, diet pills, etc.)
❑ Get rid of food after eating (laxatives, vomiting, exercise)

Where do you eat/prepare most of your meals?____
Do you purchase foods at the grocery store? ❑ Yes ❑ No
Do you read food labels? ❑ Yes ❑ No
What do you look for on labels?

Please list the reason(s) you are here today and any questions you have:
____
____
____

____
Thank you!

Office use only

24 hour food and beverage record

Breakfast

Lunch

Snack

Dinner

Snack

Food likes and dislikes:

Fruits & Veg consumed

Calories

Protein
Milk

Veg/Frt

Brd/Starch

: