Nutrition Assessment

Name:_____ Date of Birth:_____
Age:_____ Height:_____ Weight:_____ Occupation:_____
Home Phone:_____ Cell:_____ Work:_____
Address:_____City:_____State:_____Zip:_____

Emergency Contact:
Name:_____ Phone Number:_____ Relationship:_____

Please list other healthcare providers with whom you are working:

Physician:_____ Therapist:_____
Psychiatrist:_____ Other:_____

Medical History
Please indicate whether you have or have had any of the following conditions:
□ High Cholesterol □Diabetes Mellitus □High Blood Pressure □ Kidney Disease □ Cancer □Osteoporosis
□Intestinal problems □Heart Attack □Stroke □Obesity □Mental Health Issues □ Other_____

Are you currently experiencing any of the following: □ Diarrhea □ Constipation □ Reflux/Heartburn □ IBS □ Nausea
□ Cold Intolerance □ Dizziness/Fainting □ Shortness of Breath □ Fatigue □ Sleep Disturbance □Difficulty Chewing or Swallowing

Other Past Medical History(diagnoses, surgeries):_____
Are you currently being treated for any medical conditions? □ Yes □ No Explain:_____
_____
List medications you are currently taking:_____
_____
List food and/or vitamin & mineral supplements you are currently taking:_____
_____
Do you have any food allergies or food intolerances? □Yes □ No If yes, please explain:_____
_____
Has your doctor or another healthcare professional ever recommended you follow a special type of diet? □Yes □ No
Explain:_____

Are you currently following a special type of diet? □Yes □ No If yes, what type of diet?_____
_____

Do you drink alcohol? □ Yes □ No Number of drinks per week:_____
Do you smoke cigarettes? □ Yes □ No □Quit Amount per day:_____
Do you use drugs? □ Yes □ No Explain:_____
_____

How much decaffeinated fluid (decaf coffee/tea/soda, water) do you drink per day?_____

How much caffeinated fluid (coffee, tea, soda, energy drinks) do you drink per day?_____

Preventative care screenings and diagnostic tests you have had: (please check all that apply):

□ Bone Density □Colonoscopy □Cardiac Stress Test □Mammogram □Prostate/Testicular Exam

When was the last time you had labs drawn?_____

If you have most recent lab results available, please bring a copy of them to your first appointment.

Female Clients:

Are you currently menstruating? □ Yes □ No □Haven't started □ Post-menopausal If no, what was your weight at the time of your last menstrual cycle? _____ Date of last menstrual cycle:_____ Age you started menstruating:_____

Are you taking birth control pills or estrogen pills? □ Yes □ No

Weight History

Do you weigh yourself? □ Yes □ No How often?_____ Where?_____

What has your highest weight ever been? _____ Age:_____ How long were you at this weight?_____

Describe eating and exercise patterns at this weight:_____

_____

What has your lowest weight been?_____ Age:_____ How long were you at this weight?_____

Describe eating and exercise patterns at this weight:_____

_____

What has been your most stable adult weight?_____ How long were you at this weight?_____

Are you satisfied with your current weight? □ Yes □ No If no, why not?_____

What is your desired weight?_____ Have you ever weighed this? □ Yes □ No When?_____

If yes, describe eating and exercise patterns at this weight:_____

What do you think your set-point, or *natural body weight is? _____ Is this an acceptable weight for you? □ Yes □ No

(*A natural body weight is a weight that is fairly easy to maintain with normal eating behaviors and exercise patterns)

How old were you at this weight?_____ How long were you at this weight?_____

Describe eating and exercise patterns at this weight:_____

_____

If weight loss is your goal, what do you think weighing less will do for you?_____

_____

Dieting History

Have you ever tried to lose weight through dieting? □ Yes □ No

How old were you when you started dieting? _____ What was your weight at the time you started to diet?_____

Have you ever been successful at any attempts to lose weight? □ Yes □ No If yes, when and why were you successful?_____

_____

Please indicate with a check (√) whether or not you have attempted to control your weight by engaging in any of the following behaviors and/or using the following substances. Please use the blank line to describe type of diet(s), results of the diet(s), frequency and duration of using the substance or behavior. Please also note when you were using the behaviors/substances and please note if any of the items you checked yes to are currently active.

Fad diets	□Yes □ No	
Diet pills	□Yes □ No	
Count calories/carbs	□Yes □ No	
Diuretics	□Yes □ No	
Laxatives	□Yes □ No	
Vomiting	□Yes □ No	
Liquid diets	□Yes □ No	
Colon cleanses	□Yes □ No	
Ipecac	□Yes □ No	
Fluid Restriction	□Yes □ No	

*Binge Eating:
Do you currently struggle with binge eating? □Yes □ No If yes, how often? What time of day? Where?_____
_____
If no, have you ever struggled with binge eating in the past? □Yes □ No If yes, when?_____
_____

Exercise History
Do you currently exercise? □Yes □ No If yes, describe the type, frequency, duration, and intensity of exercise:
_____
_____

Have you ever struggled with compulsive/excessive exercise in the past? □Yes □ No If yes, when? _____

Do you enjoy exercise? □Yes □ No
Do you have any exercise goals? Please list:_____

Behavior Change
Readiness: on a scale from 0-10 (0=not very ready, 10=very ready) How ready are you to change your eating behaviors?_____

Confidence: on a scale from 0-10 (0=not very confident, 10=very confident) How confident are you in your ability to change?_____

What are 1-2 things you would like to change about your diet? 1. 2.

What are some barriers that might make it challenging for you to make changes?_____
_____

Client Signature:_____ Date:_____

Dietitian Signature:_____ Date Reviewed:_____

Dietitian Notes: