Nutrition Assessment

Nutrition, llc

Date: Date of birth: Age:

Patient's Name:

Race: Height: Sex:

Lowest Weight: Highest Weight: Current Weight:

Primary Care Physician:

Home Phone: Work / Cell Phone:

What is your education level?: ☐ 8th grade or less ☐ some high school ☐ high school diploma ☐ some college ☐ college degree ☐ any postgraduate

Do you have any of the following?:

Medical history: Check all that apply

- ☐ Diabetes
- ☐ Vision Problems
- ☐ Numbness
- ☐ Pain
- ☐ Tingling
- ☐ Thickened nails
- ☐ Burning
- ☐ Sores
- ☐ Ulcers
- ☐ Swelling
- ☐ Bloating
- ☐ Constipation
- ☐ Diarrhea
- ☐ Reflux
- ☐ Kidney disease
- ☐ Foot Problems

Frequent Infections:

☐ Urinary tract ☐ Yeast ☐ Sinus ☐ Other

Circulatory System:

- ☐ Vascular disease
- ☐ Stroke
- ☐ Asthma
- ☐ Circulation problems
- ☐ High blood pressure
- ☐ Thyroid disease
- ☐ Heart disease
- ☐ High Cholesterol
- ☐ High Triglycerides

Have you had diet education previously? ☐ Yes ☐ No

If yes, where and for what reason?

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Have you been hospitalized in the last thee month? ☐ Yes ☐ No

Describe why:

Please list your last known blood pressure: _____ mmHG

List any other medical conditions:

Surgeries:

List any Medications, Minerals, Vitamins or Herbal Supplements you Take:

Exercise habits: (What type ie Cardio, how long & how often?)

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What are some things that interfere with your ability to follow a healthy meal plan:

Do you drink alcohol? ☐ Yes ☐ No # Of drinks per _____ week

Do you use tobacco? ☐ Yes ☐ No # Of packs per day_____

Occupation:

What shift do you work:

Days of the week you work:
☐ Su ☐ M ☐ T ☐ W ☐ T ☐ F ☐ S

Are you stressed over work or family issues? ☐ Yes ☐ No

Explain:

Weight change in the last six months: ☐ Yes ☐ No

Explain:

Previous diets:

Who does your food shopping?

Who cooks for your family?

How often do you eat out?

Where do you eat out most?

Do you have any diet restrictions (ie religious dietary needs, allergies, intolerances)

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Are you currently following a diet? ☐ Yes ☐ No

What type of diet?

What is your main nutrition concern today?

What does a typical day look like? What do you eat and drink? What time?

Breakfast Time:	Morning Snack Time:	Lunch Time:	Afternoon Snack Time:	Dinner Time:	Bedtime Snack Time:

Dietitian's notes