NUTRITION ASSESSMENT

Name: _____ DOB/Age: _____ Gender: _____Email:_____

Reason for consultation: _____

Prior nutrition consultation? _____

Health & Medical History: Check all that Apply by filling in Box with C (current) or P (Past):

☐ Addiction (coffee/cigarettes/ sugar/ alcohol or other substances)
☐ ADHD
☐ Food Allergies ☐Environ. ☐Seasonal
☐ Anxiety / Depression / Mood swings
☐ Arthritis ☐ Osteo☐ Rheumatoid
☐ Asthma
☐ Autoimmune Condition: _____
☐ Pre-Diabetes ☐Diabetes
☐ Cancer: Type _____
☐ Celiac disease ☐Gluten intolerance
☐ Chronic fatigue syndrome/SEID
☐Eating Disorder: _____
☐ Fibromyalgia
☐ Food allergies or Intolerances
☐ GI Condition: _____
☐ GERD, Heartburn, Hiatal Hernia
☐ Headaches
☐ Heart condition
☐ High blood pressure / hypertension
☐ High cholesterol
☐ IBD: ☐Crohn's ☐Ulcerative colitis
☐ Infertility
☐ IBS: Type: _____
☐ Memory concerns ☐ MCI
☐ Menopause
☐ Neurological Disease: _____
☐ Obesity ☐ Overweight
☐ Osteopenia ☐Osteoporosis
☐ Physical limitation: _____
☐ PMS
☐ Prostate
☐ Sexual dysfunction
☐ _____
☐ _____
☐ _____

Family History:

Digestive function: ☐ Good ☐ Fair ☐ Poor Bowel Movements : ☐ Daily ☐< 1x day ☐1-2x day ☐ Diarrhea ☐ Constipation

Signs & Symptoms:

Rate your Typical energy level: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Lab & Diagnostic Data:

Medications/Supplements (vitamins, Minerals, herbs, Medical foods, etc.)	Dosage	Frequency

Height: _____ Lowest adult weight: _____ Waist: _____ Hip: _____ W/H: _____ BMI: _____ BAI:_____

Current Weight: _____ Highest adult weight: _____ Does your weight affect the way you feel about yourself? _____

Weight, 1 yr ago: ____ Desired weight: _____ Comments:

Exercise/ Activity: ☐ Yes Type: How often? How long?

☐ No Why not?

Sleep: ☐ 8+ hours ☐ 6-8 hours ☐ <6 hours Sleep Quality: ☐ Good ☐Fair ☐Poor

Life stressors:
☐ Work ☐Family ☐Finances ☐Health ☐ Relationship/ friendships ☐Other

What do you do to relax?

Comments:

DIET & FOOD HABITS:

Do you follow a particular diet/eating pattern?

☐ No ☐ Yes
☐Vegan ☐Vegetarian ☐Low carb ☐Ketogenic ☐ Paleo ☐ Gluten Free ☐ Elimination Diet ☐ Other: _____
Comments:

What are your personal challenges to eating well?

Are you aware of any adverse food reactions (allergies/intolerances)?

☐ No ☐ Yes If yes, explain:

What percentage of meals do you eat out?

☐ 90-100% ☐ 75% ☐ 50% ☐ < 50% Where?

Do you grocery shop?

☐ Yes ☐ No If not, who does?

Do you cook?

☐ Yes ☐ No If not, who does?

FOOD LOG (include 3 typical days including a weekend day – do not change how you usually eat and include all food and beverages)

Breakfast Time:	Lunch Time:	Dinner Time:	Snacks	Comments

ADDITIONAL COMMENTS: