NUTRITION ASSESSMENT

Name: _____ DOB/Age: _____ Gender: _____

Preferred Pronoun: _____ Email: _____ Cell: _____

Reason for consultation: _____
_____
_____

Health & Medical History: Check all that apply currently, circle any that applied in the past.

☐ Addiction (coffee/cigarettes/sugar/ alcohol or other substance)
☐ ADHD
☐ Food Allergies ☐ Environ. ☐ Seasonal
☐ Anxiety / Depression / Mood swings
☐ Arthritis ☐ Osteo ☐ Rheumatoid
☐ Asthma
☐ Autoimmune Condition:_____
☐ Pre-Diabetes ☐ Diabete
☐ 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 concern
☐ Menopause
☐ Neurological Disease: _____
☐ Osteopenia ☐ Osteoporosis
☐ Physical limitations:
☐ PMS
☐ Prostrate
☐ Sexual dysfunction
☐ Weight Related Concerns
☐ _____
☐ _____
☐ _____

Family medical history: _____
_____
_____

Digestive function: ☐ Good ☐ Fair ☐ Poor   Bowel movements: ☐ Daily ☐ <1x Day ☐ 1-2x day
             ☐ Diarrhea   ☐ Constipation
Digestive signs & symptoms: _____
_____

Rate your typical energy level: ☐ Excellent   ☐ Good   ☐ Fair   ☐ Poor
Please list pertinent labs (i.e., lipids, fasting, glucose, HgAIC if applicable) _____
_____
_____

Medications/supplements (vitamins, minerals, herbs, medial foods, etc.)	Dosage	Frequency

Height: _____	Lowest adult weight: _____	
Current Weight: _____	Highest adult weight: _____	Last time at desired weight?_____
Weight 1 yr ago: _____	Desired weight: _____	How long did you maintain? _____

Exercise / Activity: ☐ Yes	Type:	How often?	How long?
☐ No			
Sleep:	☐ 8+ hours ☐ 6-8 hours ☐ <6 hours	Sleep Quality: ☐ Good ☐ Fair ☐ Poor	
Life Stressors:	☐ Work ☐ Family ☐ Finances ☐ Health ☐ Relationship/freindships ☐ Other		
What do you do to relax? _____ _____			

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 2 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

Adapted from form created by Kathie Madonna Swift, MS, RDN, LDN/IFNA