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