

Nutrition Assessment

Name: _____ Age: _____ Sex: _____ Appt. Date: _____

Diagnosis/Reason for appt. _____

Prior counseling/education and date: _____

Ht _____ Wt _____ Wt changes (+/-) past year _____ Goal wt _____

Previous diets followed _____

E-mail address: (optional) _____

Please list all medications, vitamins or herbal supplements, etc. (or attach a list)

Name of Med/vitamin/herb	Reason	Dose and How often

Daily/occupational activities _____

Exercise/weight training and how often _____

How many do you eat per day: Meals: _____ Snacks: _____

Who is the primary? Food shopper _____ Food preparer _____

Frequency of eating out _____

Please include any information that will help us tailor your nutrition guidelines:

Please list 3 goals/outcomes that you would like to accomplish meeting with the dietitian.

- 1.
- 2.
- 3.

Write down what you eat and drink in a typical day and write down what time you eat.

Breakfast time:	Snack time:	Lunch time:	Snack time:	Dinner time:	Snack Time:

Beverages: _____
Alcohol Use: rare/none _____ 2-3 times a week _____ Daily _____ bimonthly _____

Signature of person completing the form: _____
Do not write below this space

Family history: _____

Labs:
Total chol. _____ HgA1C _____
HDL/LDL _____ Alb _____
Trig. _____ GTT _____
Additional notes:

Goals with pt:

- 1.
- 2.
- 3.
- 4.

Exercise goals: _____
Educational materials used: _____

Goals for f/u session:

- 1.
- 2.
- 3.
- 4.

Appointment History: