



Nutrition Assessment

NAME: _____ DATE: _____

OCCUPATION: _____

HEIGHT: _____ AGE: _____ DATE OF BIRTH: _____ F OR M

Weight Information

CURRENT WEIGHT: _____ THIS WEIGHT IS FROM: HOME SCALE PHYSICIAN'S OFFICE OTHER

WHEN DID YOU LAST WEIGH YOURSELF (OR WERE MOST RECENTLY WEIGHED)? _____

HOW OFTEN DO YOU WEIGH YOURSELF? _____ WHEN DO YOU WEIGH YOURSELF? _____

WHAT WEIGHT DO YOU MAINTAIN WITH LITTLE EFFORT? _____ AVERAGE WEIGHT FOR THE PAST YEAR? _____

AVERAGE WEIGHT IN HIGH SCHOOL? _____ COLLEGE? _____

WEIGHT WHEN YOU MARRIED? _____ WHAT YEAR WERE YOU MARRIED? _____

AT WHAT WEIGHT DO YOU FEEL COMFORTABLE? _____ WHEN WERE YOU LAST AT THAT COMFORTABLE WEIGHT? _____

WHAT MUST YOU DO TO STAY AT THAT COMFORTABLE WEIGHT? _____

IF YOU'VE GAINED WEIGHT OVER THE LAST 1-2 YEARS, WHAT WOULD YOU IDENTIFY AS THE PRIMARY CAUSE?

HIGHEST ADULT WEIGHT: _____ (AGE): _____ HOW MANY YEARS AGO? _____

LOWEST ADULT WEIGHT: _____ (AGE): _____ HOW MANY YEARS AGO? _____

PRE-PREGNANCY WEIGHT: BABY #1 _____ BABY #2 _____ BABY #3 _____ MORE? _____

HOW MUCH WEIGHT DID YOU GAIN WITH EACH PREGNANCY?
BABY #1 _____ BABY #2 _____ BABY #3 _____ MORE? _____

WERE YOU ABLE TO LOSE ALL OF THE WEIGHT YOU GAINED WITH EACH PREGNANCY? YES NO

Dieting/Weight Loss History

HAVE YOU EVER TRIED TO LOSE WEIGHT BEFORE? YES NO

1) TYPE OF DIET (WEIGHT WATCHERS, ETC): _____

DATE? _____ HOW MUCH WEIGHT DID YOU LOSE? _____ HOW LONG DID IT LAST? _____

WHAT DID YOU LIKE/DISLIKE ABOUT THIS PROGRAM? _____

2) TYPE OF DIET (WEIGHT WATCHERS, ETC): _____

DATE? _____ HOW MUCH WEIGHT DID YOU LOSE? _____ HOW LONG DID IT LAST? _____

WHAT DID YOU LIKE/DISLIKE ABOUT THIS PROGRAM? _____

3) TYPE OF DIET (WEIGHT WATCHERS, ETC): _____

DATE? _____ HOW MUCH WEIGHT DID YOU LOSE? _____ HOW LONG DID IT LAST? _____

WHAT DID YOU LIKE/DISLIKE ABOUT THIS PROGRAM? _____

ANY ADDITIONAL COMMENTS YOU WOULD LIKE TO ADD REGARDING "DIETING/WEIGHT LOSS" HISTORY?

HAVE YOU EVER USED LAXATIVES FOR WEIGHT CONTROL? YES NO

HAVE YOU EVER VOMITED FOR WEIGHT CONTROL? YES NO



Nutrition Assessment

Personal Medical History

PLEASE LIST ANY *MEDICAL DIAGNOSIS* OR *PROCEDURE(S)* YOU HAVE HAD THAT AFFECTED YOUR APPETITE, CAUSED WEIGHT GAIN/LOSS, OR REQUIRED MANAGEMENT WITH MEDICAL NUTRITION THERAPY (E.G., DIABETES):

RECENT LABORATORY TEST RESULTS FOR CHOLESTEROL, TRYGLYCERIDES, GLUCOSE, ETC, (PLEASE LIST):

DATE: _____

PLEASE LIST CURRENT OVER-THE-COUNTER (OTC) MEDICATIONS AND/OR PRESCRIPTION MEDICATIONS:

MEDICATION	DOSAGE	FREQUENCY TAKEN	HOW LONG HAVE YOU TAKEN?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

HAVE YOU EVER BEEN ADVISED BY YOUR PHYSICIAN TO FOLLOW A SPECIAL DIET? (LOW SODIUM, LOW CHOLESTEROL, NO SUGAR, ETC.)? YES NO IF YES, WHEN? _____

WHAT CHANGES DID YOU MAKE AT THAT TIME? _____

HAVE YOU EVER WORKED WITH A DIETITIAN/NUTRITIONIST? YES NO

IF YES, WHAT WAS YOUR EXPERIENCE? _____

Personal Health History

DO YOU TAKE VITAMIN, MINERAL, OR FOOD SUPPLEMENTS? YES NO

PLEASE LIST CURRENT SUPPLEMENTS:

SUPPLEMENT	DOSAGE	FREQUENCY	HOW LONG HAVE YOU TAKEN?	TO TREAT WHAT CONDITION?
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

ADDITIONAL COMMENTS RE: SUPPLEMENTATION: _____



Nutrition Assessment

DO YOU HAVE ANY FOOD ALLERGIES? YES NO

PLEASE SPECIFY: _____

HOW WERE YOUR ALLERGIES DIAGNOSED? _____

WHEN WERE YOUR ALLERGIES DIAGNOSED? _____

DO YOU HAVE ANY FOOD INTOLERANCES? YES NO

PLEASE SPECIFY: _____

HOW WAS YOUR FOOD INTOLERANCE DIAGNOSED? _____

WHEN WAS YOUR FOOD INTOLERANCE DIAGNOSED? _____

ARE YOUR MENSTRUAL PERIODS REGULAR? YES NO NA

ARE YOU EXPERIENCING PERI-MENOPAUSAL SYMPTOMS (TENSION, PAIN, IRRITABILITY, INTERRUPTED SLEEP, ETC.) AROUND THE TIME OF YOUR PERIOD? YES NO IF YES, PLEASE EXPLAIN: _____

HAVE YOU ENTERED MENOPAUSE (12 CONSECUTIVE MONTHS W/OUT A MENSTRUAL PERIOD)? YES NO

HOW LONG SINCE YOUR MENSTRUAL CYCLE CEASED? _____

WAS YOUR MENOPAUSE NATURAL OR SURGICALLY/MEDICALLY INDUCED? _____

DOES YOUR APPETITE OR DO YOUR FOOD CHOICES CHANGE WITH YOUR MENSTRUAL CYCLE? YES NO

IF YES, HOW? _____

DO YOU SMOKE? YES NO IF YES, HOW LONG HAVE YOU SMOKED? _____

IF YES, HOW MUCH DO YOU SMOKE? _____

ON AVERAGE, HOW MANY HOURS DO YOU SLEEP EACH NIGHT? _____

ON A SCALE OF 1 – 10, 10 BEING THE HIGHEST, PLEASE RATE YOUR STRESS LEVEL. _____

WHAT WOULD YOU IDENTIFY AS THE PREDOMINANT SOURCE OF YOUR STRESS? _____

WHAT DO YOU DO TO MANAGE STRESS? _____

Family Health History

AGE | HEALTH CONDITION(S) | WEIGHT (CURRENT AND HISTORY)

MOTHER: _____

FATHER: _____

SIBLING: _____

SIBLING: _____

Eating Patterns

HOW MANY DAYS PER WEEK DO YOU EAT (BREAKFAST) _____ (LUNCH) _____ (DINNER) _____

HOW OFTEN DO YOU SNACK DURING THE DAY? ONCE TWICE THREE TIMES CONTINUALLY

WHEN DO YOU TYPICALLY SNACK? _____

WHAT FOODS DO YOU SNACK ON MOST FREQUENTLY? _____

DO YOU DRINK ALCOHOL? YES NO

IF YES, WHAT DO YOU DRINK? BEER WINE MIXED DRINKS OTHER _____

NUMBER OF ALCOHOLIC BEVERAGES PER DAY: _____

HOW MANY MEALS AND SNACKS DO YOU EAT PER WEEK, THAT ARE NOT HOME COOKED? INCLUDE BREAKFAST/LUNCH/DINNER, AND CONSIDER ANY MEAL OR SNACK THAT YOU PURCHASE FAIR GAME.

WHAT TYPE OF RESTAURANT(S) DO YOU NORMALLY CHOOSE (MEXICAN, ITALIAN, FAST FOOD, FAST CASUAL, FINE DINING, ETC.)? _____

HOW DOES YOUR MEAL AND SNACK PATTERN VARY ON THE WEEKEND VS. DURING THE WEEK?

DO YOU TRAVEL AND/OR ENTERTAIN FOR BUSINESS? YES NO IF YES, HOW OFTEN? _____

WHAT ARE YOUR FAVORITE FOODS? _____

WHAT FOODS DO YOU AVOID EATING AND WHY: _____

DO YOU HAVE A LIST OF "SAFE" FOODS? YES NO NOT CERTAIN WHAT THIS MEANS

IF YES, WHAT ARE THEY? _____

Awareness of Food and Eating Patterns

- | | |
|--|---|
| DO YOU EAT STANDING UP? | <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> SOMETIMES |
| DO YOU EAT IN THE CAR? | <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> SOMETIMES |
| DO YOU EAT AT THE KITCHEN/DINING ROOM TABLE? | <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> SOMETIMES |
| DO YOU ENGAGE IN OTHER ACTIVITIES WHEN YOU EAT? | <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> SOMETIMES |
| DO YOU FEEL THAT YOU EAT FAST? | <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> SOMETIMES |
| DO YOU FEEL COMFORTABLE EATING IN FRONT OF OTHERS? | <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> SOMETIMES |
| DO YOU EAT WITH OTHERS OR ALONE MOST OFTEN? | <input type="checkbox"/> OTHERS <input type="checkbox"/> ALONE |

Kitchen Skills Assessment

- | | |
|----------------------|---|
| DO YOU COOK? | <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> SOMETIMES |
| DO YOU LIKE TO COOK? | <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> SOMETIMES |

IF YOU DON'T COOK, PLEASE EXPLAIN HOW YOU NOURISH YOURSELF. _____

IF YOU COOK FROM RECIPES, WHAT SOURCE(S) DO YOU TYPICALLY USE?

MAGAZINES COOKBOOKS FAMILY RECIPES

WEBSITES PLEASE SPECIFY _____

WHO TYPICALLY PREPARES THE FOOD AT HOME? _____

WHO TYPICALLY DOES THE GROCERY SHOPPING? _____

DO YOU READ NUTRITION FACTS OR INGREDIENT LABELS? YES NO

IF YES, WHAT DO YOU LOOK FOR? _____

Eating and Emotion

DO YOU, OR HAVE YOU EVER, USED FOOD FOR COMFORT OR TO ADDRESS OTHER EMOTIONS? YES NO

IF YES, PLEASE ELABORATE: _____

ON A SCALE OF 1-10, 10 BEING THE HIGHEST, HOW MUCH SUPPORT DO YOU NEED WHEN MAKING LIFESTYLE CHANGES? _____

DO YOU HAVE A STRONG SUPPORT SYSTEM? YES NO

Exercise and Activity

DO YOU *CURRENTLY* FOLLOW A CONSISTENT EXERCISE ROUTINE? YES NO

IF YES, HOW MANY DAYS/WEEK? _____ HOW LONG ARE YOUR EXERCISE SESSIONS? _____

IF NO, WHEN DID YOU LAST FOLLOW A CONSISTENT EXERCISE ROUTINE? _____

PLEASE CHECK ALL ACTIVITIES THAT YOU CURRENTLY ENGAGE IN CONSISTENTLY:

- | | |
|--|--|
| <input type="checkbox"/> STEP AEROBICS CLASS | <input type="checkbox"/> YOGA |
| <input type="checkbox"/> SPIN CLASS | <input type="checkbox"/> PILATES |
| <input type="checkbox"/> WATER AEROBICS CLASS | <input type="checkbox"/> FREE WEIGHTS |
| <input type="checkbox"/> ELLIPTICAL MACHINE | <input type="checkbox"/> WEIGHT MACHINES |
| <input type="checkbox"/> TREADMILL | <input type="checkbox"/> RUNNING |
| <input type="checkbox"/> STATIONARY BICYCLE | <input type="checkbox"/> WALKING |
| <input type="checkbox"/> SPECIALTY GROUP FITNESS CLASS | <input type="checkbox"/> OTHER |

DO YOU LIKE TO EXERCISE? YES NO

WHAT PHYSICAL ACTIVITY DO YOU DISLIKE? _____

WHEN YOU FEEL OVERWHELMED OR LIFE GETS BUSY,
DO YOU NEGLECT YOUR EXERCISE ROUTINE? YES NO

THANK YOU!

ALL INFORMATION IS STRICTLY CONFIDENTIAL.

PLEASE BRING THIS FORM WITH YOU TO YOUR FIRST APPOINTMENT SCHEDULED FOR:

DATE: _____ @ TIME: _____