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Nutritional Assessment Form

Date: _____

Name: _____
Address: _____
Phone:_____ Email: _____
Date of Birth: _____ Sex: ___ Height: ____ Weight: _____ Usual Weight: _____
Date of Last Medical Checkup: _____

Health History
Have you been told that you have (check any that apply):
Diabetes ____ Heart disease ____ Ulcers ____ GI disorders ____ Lung disease ____
Cancer ____ High blood pressure ____ Kidney disease ____
Hardening of the arteries (atherosclerosis)____ Liver disease _____
Do you have any complaints about any of the following:
Lack of appetite ____ Diarrhea ____ Nausea ____
Difficulty chewing or swallowing ____ Indigestion ____Vomiting ____
Constipation ____ Fever ____ Other _____

For females: Are you pregnant? _____ How many months? _____ How many pregnancies have you carried to term? _____ When was your last child born? _____
Are your menstrual periods normal? _____ If not, please explain: _____

Drug History
Do you take medication, either prescribed by a doctor or over-the-counter?
Name of drug/medicine Reason for taking Dose/Frequency Duration of intake

_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____
Have you noticed any side effects from taking these medications? _____
If so, please explain: _____

Do you take vitamins or any kind of supplements? _____
Which ones? _____
How often? _____
For what reason?_____

Diet History
Have you recently lost or gained more than 10 lbs? _____
If yes, explain the surrounding circumstances (including associated illness, dietary changes, and time frame): _____
_____
Do you eat at regular times each day? _____ How many times per day? _____
Do you usually eat snacks? _____ When? _____
What foods do you particularly like? _____
_____
Are there foods you don't eat for other reasons? _____
Do you have difficulty eating? _____
How would you describe your feelings about food? _____
_____
How do your eating habits change when you are emotionally upset? _____
_____
Are you, or any member of your family, on a special diet? _____
If yes, who and what kind? _____
Do you drink alcohol? _____ How much? _____ How often? _____
Do you smoke cigarettes? _____ How many? _____ How often? _____
How would you describe your exercise habits? _____
Type of exercise _____
Intensity _____ Duration _____ Frequency _____
Are there any other facts about your lifestyle that you think might be related to your nutritional health? _____
Please explain _____
_____
_____
Please use the following space to give your reasons for consulting a nutritionist and to explain what your nutritional goals may be. Thanks. _____
_____
_____
_____
_____
_____
_____
_____