The Pearl Clinic
pearlclinicllc.com

Initial Nutrition Assessment Form

(Please complete the form below)

Client Name:_____

Date:_____

1. Please briefly explain your reason for seeing a Dietitian today:

2. List your top 3 health & wellness concerns in order of importance:

1.

2.

3.

3. Circle the main motivators for changing your diet.

a. Improved self-confidence

b. Weight loss

c. Increased energy

d. Improved athletic performance

e. Improved health (ie: blood glucose, cholesterol levels, blood pressure)

f. Prevention of diseases I am at risk for

g. Other:_____

The Pearl Clinic
pearlclinicllc.com

4. On a scale from 1-10 *(1 being "not at all" and 10 being "ready today")* How ready are you to make lifestyle & diet changes for your health? *(Circle your answer.)*

< 1 2 3 4 5 6 7 8 9 10 >

5. Have you tried to make changes to your diet in the past? *(Circle one.)* Yes No

6. What obstacles have you faced or might you face when trying to improve your diet? *(Circle all that apply.)*

a. Emotional stress

b. Work schedule/requirements

c. Lack of support from relatives/friends/coworkers

d. Lack of time to prepare healthy meals

e. Lack of money to buy nutritious foods

f. Frequent travel

g. Other:_____

7. How many meals do you eat per day? _____

8. How many snacks do you eat per day? _____

9. How many days a week do you eat fruit? *(Circle one.)*

Every day 5 days/wk 3days/wk 1-2days/wk Never

10. How many days a week do you eat vegetables? *(Circle one.)*

Every day 5 days/wk 3days/wk 1-2days/wk Never

The Pearl Clinic
pearlclinicllc.com

11. Do you smoke? *(Circle one.)* Yes No If yes, how many cigarettes/cigars per day? _____

12. Do you drink alcoho? *(Circle one.)* Yes No

If ***yes***, how often do you consume alcohol? *(Circle one.)*

Daily A few times per week A few times per month

13. How often do you drink coffee? *(Circle one.)*

Never 1 cup/day 2-3 cups/day 4 or more cups/day

14. How often do you consume soda or sweetened beverages like tea or lemonade? *(Circle one.)*

Never Daily A few times per week A few times per month

15. Do you often overeat? *(Circle one.)* Yes No

If yes, how often and why?

_____

_____

_____

The Pearl Clinic
pearlclinicllc.com

16. What types of food do you typically crave? *(Circle all that apply.)*

a. Sweets/desserts

b. Chocolate

c. Bread/pasta

d. Fried foods/salty foods

e. Dairy

f. Meats

g. Alcoholic Beverages

h. Other:_____

17. Do you experience any of the following if you haven't eaten in a while? *(Circle one.)*

Every day 5 days/wk 3days/wk 1-2days/wk Never

18. How often do you eat at home/cook your own meals? *(Circle one.)*

All meals 1-2/day 1/day Rarely Never

19. Who does the cooking/food shopping? _____

20. How often do you have bowel movements? *(Circle one.)*

3+/day 1-2/day Every other day Once a week or less

21. How often do you urinate in a 24 hour-period? _____

The Pearl Clinic
pearlclinicllc.com

22. The condition of your skin and hair is: *(Circle one.)*

Very Dry Dry Normal Oily

23. Please rate your energy level: *(Circle one.)*

Excellent Good Fair Poor

24. How would you rate your quality of sleep? *(Circle one.)*

Excellent Good Fair Poor

25. Do you often wake up at night and eat? *(Circle one.)* *Yes* *No*

26. How many days a week you exercise, how long each session lasts, and what you do for exercise:

_____

_____

27. List any food allergies/sensitivities you have as well as foods you avoid for religious or personal reasons:

_____

_____

28. Is there anything else you would like to share with your Dietitian?

_____

_____

The Pearl Clinic
pearlclinicllc.com

Thank You!

Weight Questionnaire

(Complete this page ***only*** if you are interested in weight loss or weight gain.)

1. Describe your present weight: (*Circle one.*)

Very overweight/Obese Slightly overweight Healthy Weight Underweight

2. How do you feel about the way you look at this weight? (*Circle one.*)

Extremely unhappy Unhappy Neutral Happy Very happy

How much do you / did you weigh:

Now:_____

3 months ago:_____

6 months ago:_____

1 year ago:_____

Height:_____

3. At what weight have you felt your best or do you think you would feel your best?_____

4. How much weight would you like to Lose or Gain?_____

5. Do you feel your weight affects your daily activities? (*Circle one.*)

All the time Often Rarely Not at all