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:________________________________________________________________________________
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 3 days/wk 1-2 days/wk Never

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

Every day 5 days/wk 3 days/wk 1-2 days/wk Never
11. Do you smoke? (Circle one.) Yes No If yes, how many cigarettes/cigars per day? _______

12. Do you drink alcohol? (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?

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________
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        3 days/wk        1-2 days/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? ____________________________________
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?

____________________________________________________________________________________
____________________________________________________________________________________
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