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
   e. 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)? 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)?
   Every day  5 days/wk  3 days/wk  1-2 days/wk  Never

10. How many days a week do you eat vegetables (circle)?
    Everyday  5 days/wk  3 days/wk  1-2 days/wk  Never

11. Do you smoke (circle)?  Yes  No  If yes, how many cigarettes/cigars per day? ___

12. Do you drink alcohol (circle)? Yes  No
    If yes, how often do you consume alcohol (circle)?
13. How often do you drink coffee (circle)?

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)?

Never daily A few times per week A few times per month

15. Do you often overeat (circle)? Yes No

If Yes, how often and why?
_______________________________________________________________
_______________________________________________________________

16. What types of food do you typically crave (circle)?
a. Sweets/desserts
b. Chocolate
c. Bread/pasta
d. Fried foods/salty foods
e. Dairy
f. Meats
g. Alcoholic beverages

17. Do you experience any of the following if you haven’t eaten in a while (circle)?

Irritability lightheadedness weakness

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

All meals 1-2/day 1/day rarely

19. Who does the cooking/food shopping? __________________________

20. How often do you have bowel movements (circle)?
21. How often do you urinate in a 24 hour-period? ________

22. The condition of your skin and hair is (circle):
   Very dry       dry       normal       oily

23. Please rate your energy level (circle):
   Excellent       Good       Fair       Poor

24. How would you rate your quality of sleep (circle)?
   Excellent       Good       Fair       Poor

   How many hours of sleep do you get per night? _____

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

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

27. Please list any food allergies/sensitivities you have as well as certain 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 (circle) Lose or Gain? __________________**

6. **Do you feel your weight affects your daily activities (circle one)?**

   All the time  Often  Rarely  Not at all
7. What weight loss/fitness/lifestyle programs have you tried in the past (check all that apply)?

- Diet on your own
- LA Weight Loss
- Weight Watchers
- Exercise at home
- Jenny Craig
- NutriSystem
- Doctor run weight loss
- Gym/Personal Trainer
- Bariatric Surgery
- RD or nutritionist
- Other: ______________________________

Thank You!

Client Information Form

Please provide the following information

Date: ______________________________

Full name (first, middle, last): ______________________________________________________

Street Address:

________________________________________________________________________________

City: _____________________________ State: _________ Zip Code: ________________________

Cell phone: __________ Home telephone: __________ Work telephone: _________________

Email: ______________________ Marital Status: __ Married __ Divorced __ Single __ Other _______

Date of Birth: ______________ Gender: __ Male __ Female Social Security number: ____________

Name of employer: __________________ Occupation: _________________________________

Highest Level of Education: __ High School __ Some College __ College Degree __ Graduate Degree

Emergency contact name: __________ Telephone number: ___________________________

Relationship of emergency contact to you: ______________

Please list all your physicians that you see on a regular basis:

1. ____________________________
2. 

3. **Diagnosed Medical Conditions** (please circle if you have any of the following even if you are taking medication to control the condition):

- Diabetes
- High blood pressure
- High cholesterol
- Obesity
- Kidney
- Heart disease
- Cancer
- Thyroid
- GI problems
- Other: ______________________________

What is your primary language?

________________________________________

List of all medications/supplements/vitamins/herbs you are currently taking: