Name:_____ DOB:_____

# Nutrition Assessment Form

Age: _____

E-mail Address: _____ Phone: _____

Live with: ☐Spouse ☐Family ☐Friend ☐Alone

Employment: ☐Full-Time ☐Part-Time ☐Retired ☐Student ☐Other _____

Occupation: _____ Work Hours: _____

Have you seen a dietitian before? ☐Yes ☐No

If yes, for what diet? _____ When? _____ Where? _____

Have you had any previous weight loss surgeries? ☐Yes ☐No

If yes, what type(s)? _____ When? _____

Diets/Weight plans tried in the past:_____

_____

Height: _____ Present Weight: _____

Highest Adult Weight/Age: _____ Lowest Adult Weight/Age: _____

Recent weight change? ☐Yes ☐No How many pounds lost? _____ Gained? _____

What would you like to weigh? _____

What age did you begin to gain excess weight? _____

Looking back, what would you attribute the weight gain to at that time? _____

_____

What is the main reason you have been unable to lose weight (or maintain lost weight)? _____

_____

Name:_____ DOB:_____

**Please check if you are currently taking any of the following:**

☐ Multi-vitamins: brand: _____

☐ Single Vitamins (Vitamin C, E, etc): type(s): _____

☐ Calcium: type: _____ amount: _____

☐ Herbs: type(s): _____

☐ Other: _____

Food Allergies/ Intolerances: _____

_____

**Please check (✓) everything below that describes your eating pattern and/or lifestyle behaviors:**

| | | | |
|---|---|---|---|
| | 1. I eat large portions, get seconds or overfill my plate | | 11. I don't take time to plan healthy meals ahead |
| | 2. I skip meals or go for longer than 5 hours between meals | | 12. I am tempted by family/friends to eat unhealthy foods |
| | 3. I dine out (includes carry-out) more than 3 times a week | | 13. I lack the knowledge to cook healthy |
| | 4. I frequently eat fried foods, fast foods and high fat foods | | 14. I never feel "full" or satisfied after eating |
| | 5. I frequently eat sweets and desserts (candy, cakes, cookies) | | 15. When dieting, I go to extremes |
| | 6. I graze (snack on food all day long while doing other things (reading, watching TV, computer work) | | 16. I drink less than 64 ounces (8 cups) daily (all fluids count) |
| | 7. I eat too quickly | | 17. I usually drink two or more alcoholic beverages daily |
| | 8. I am an emotional eater (I eat when I am stressed, bored, anxious…) | | 18. My work schedule hinders my weight loss efforts |
| | 9. I am so busy, I forget to stop and eat | | 19. I would have a difficult time reducing or giving up: _____ |
| | 10. I am a "picky" eater | | Other: |

Name:_____ DOB:_____

# Goals & Readiness Assessment

1. I want to see a dietitian because:

_____

_____

2. My nutrition-related goals are:

_____

_____

_____

3. If I could change 3 things about my health & nutritional habits, they would be:

_____

_____

_____

4. The biggest challenge(s) to reaching my nutrition goals are:

_____

_____

_____

Name:_____ DOB:_____

# Food Log


Week of:_____ Weight:_____

*** Please record the portions consumed (ie. Cups, ounces, tablespoons) and the time of your meals & snacks!**

| Breakfast | Lunch | Dinner | Snacks |
|---|---|---|---|
| | | | |
| Breakfast | Lunch | Dinner | Snacks |
| | | | |
| Breakfast | Lunch | Dinner | Snacks |
| | | | |
| Breakfast | Lunch | Dinner | Snacks |
| | | | |
| Breakfast | Lunch | Dinner | Snacks |
| | | | |
| Breakfast | Lunch | Dinner | Snacks |
| | | | |
| Breakfast | Lunch | Dinner | Snacks |
| | | | |