Assessment Form

Name: _____ Date of Birth: _____ Date_____

Street Address: _____ City: _____ State: _____ Zip: _____

Telephone: (day)_____ (evening)_____May I leave a message?_____

Email: _____ Fax:_____

Section I. Medical

Reason for nutrition counseling_____

Current Medical diagnosis_____

_____

Pertinent Lab values (glucose, cholesterol, etc.)_____

_____

_____

List Medical History_____

_____

Male ☐ Female ☐ Height_____ Weight_____ Goal Weight_____

Usual Weight_____ (Highest_____ at age_____) (Lowest_____ at age_____)

Please list Medications you are taking_____

_____

_____

Section II: Diet

List vitamins & mineral supplements you are taking_____

_____

_____

Other supplements (herbal, weight loss, sports, etc.)_____

_____

Food allergies_____

Food dislikes_____

List foods you avoid for religious/ethical/cultural reasons_____

_____

List favorite foods_____

_____

Previous diet experience (type, weight lost, reason success or failed)_____

_____

_____

_____

Percentage of meals eaten at: restaurants or fast food _____% at home_____%

How much do you drink daily? Please list in cups or ounces

coffee/tea _____(decaf/regular) soda _____(brands)_____

water_____ alcohol_____ (type)_____

Section III: Lifestyle

I consider myself: sedentary ☐ somewhat active ☐ moderately active ☐ active ☐

Types of exercise & frequency per week_____

_____

_____

Health, Nutrition and Fitness Goals_____

_____

_____