Initial Nutrition Assessment Form

(Please email or fax back the completed form prior to your appointment)

Name **[Type your name]** **Date:** _____

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

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

I.

II.

III.

3. What are 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? (Highlight or underline 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? Yes No

6. What obstacles have you faced or might you face when trying to improve your diet (Choose 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. Do you smoke? Yes No If yes, how many cigarettes/cigars per day?

8. Do you drink alcohol? Yes No

If yes, how often do you consume alcohol?

Daily

A few times per week

A few times per month

9. How often do you drink coffee?

Never

1 cup/day

2-3 cups/day

4 or more cups/day

10. How often do you consume soda or sweetened beverages like tea or lemonade?

Never

Daily

A few times per week

A few times per month

11. Do you often overeat? Yes No

If Yes, how often and why?

12. What types of food do you typically crave?

a. Sweets/desserts

b. Chocolate

c. Bread/pasta

d. Fried foods/salty foods

e. Dairy

f. Meats

g. Alcoholic beverages

13. Do you experience any of the following if you haven't eaten in a while?

Irritability

Lightheadedness

Weakness

14. How often do you eat at home/cook your own meals?

15. Who does the cooking/food shopping?

16. How often do you have bowel movements?

3+/day

1-2/day every other day

Once a week or less

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

18. The condition of your skin and hair is:

Very dry

Dry

Normal

Oily

19. Please rate your energy level:

Excellent

Good

Fair

Poor

20. How would you rate your quality of sleep?

Excellent

Good

Fair

Poor

How many hours of sleep do you get per night?

21. Do you often wake up at night and eat? Yes No

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

23. Please list any food allergies/sensitivities you have as well as certain foods you avoid for religious or personal reasons:

24. Is there anything else you would like to share with us?

Diet Log

25. Below, please provide an example of a typical day of eating Breakfast –lunch and Dinner. Include any snacks, time of meals, and portions

26 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:

27. What is your primary language?

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

Weight Questionnaire

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

1. Describe your present weight:

Very overweight/Obese

Slightly overweight

Healthy Weight

Underweight

2. How do you feel about the way you look at this weight?

Extremely unhappy

Unhappy

Neutral

Happy

Very happy

3. How much do you / did you weigh:

Now:

3 months ago:

6 months ago:

1 year ago:

Height:

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

5. How much weight would you like to: Lose or Gain?

6. If applicable, please describe your "ideal body" or the physique you would like to obtain?

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

□ Gym/Personal Trainer

□ Bariatric Surgery

□ RD or nutritionist

□ Other:

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:

Date of Birth:

Gender: