nutrition sense
NUTRITIONAL COUNSELING

NUTRITION ASSESSMENT

DOB: _____ Date of Service: _____

Reason for today's visit:

_____

1. Have you ever worked with a dietitian/nutritionist? ❑ YES ❑ NO If yes, who:

2. List any medications that you are currently taking:

_____

_____

3. List any herbal and/or vitamin/mineral supplements you are currently taking:

_____

_____

4. Please estimate your current activity level:

_____

5. Any symptoms of: Nausea Vomiting Diarrhea Constipation Gas

6. How would you describe your appetite? _____

7. Height _____ Weight _____ Usual Body Weight _____

Weight History: _____

_____

8. Medical History (circle all / any that apply):

Diabetes	Hypertension	High Cholesterol	Heart Disease
Sleep Apnea	Obesity	Breathing Problems	Reflux
Osteoporosis	Stomach Problem	Thyroid Disease	Arthritis
Depression	Stroke	Headaches	Eye problems

Autoimmune PCOS Infertility

Cancer (if yes, what kind)

_____

Other: (if you have a condition not listed above, please list it here)

_____

9. Family Medical History: (please list any medical problems your immediate family suffers/ed from)

_____

_____

10. Do you smoke cigarettes? _____ If yes, for how long_____How much _____

11. Do you drink alcohol? Daily Occasionally Never

12. Are you currently employed: Yes No

Occupation:_____

13. Do you have any allergies to medication? Yes No

If yes, which _____

14. Do you have any allergies to food? Yes No

If yes, which _____

15. Other allergies: _____

16. Energy: (0 lowest/10 highest) _____ Stress: (0 lowest/10 highest) _____

17. Is there any other medical information concerning you that we should be aware of?

_____

18. List any goals you hope to achieve as a result of nutrition counseling:

_____

19. Please list anything else that you would like us to know:

_____