Nutrition Assessment

Name:	**Date of Birth:**
Today's Date:	**Circle One:** Student Faculty Staff Private

Reason(s) for Nutrition Consult:

_____
_____
_____

Food and Nutrition-Related Goals:

_____
_____

Overall Health Goals:

_____
_____

Current Eating Pattern

(Include what is eaten on a typical day, details related to dining out, portion sizes, convenience items, etc.)

	Typical Foods Consumed
Breakfast Approx. Time(s):	
Lunch Approx. Time(s):	
Dinner Approx. Time(s):	
Additional Meals Approx. Time(s):	
Daytime Snacks Approx. Time(s):	
Nighttime Eating Approx. Time(s):	

Does your eating pattern change on the weekends? If so, please describe.

_____
_____

List any vitamins or supplements you take on a regular basis:

_____
_____

Habits, Choices and Situations Impacting Nutrition

If you could change three things about your health and nutrition habits, they would be:

1._____

2. _____

3. _____

The biggest challenge(s) to reaching your nutrition and health goals is/are:

_____

_____

In the past, what techniques and/or behaviors have you used to reach your nutrition goals:

(Examples: healthy eating and exercise, specific diets, detoxes, cleanses, smoking, ADD/ADHD or other stimulant medication, skipping meal, fasting, weight loss pills, etc.)

_____

_____

The nutrition/eating habits you are most please with are:

_____

_____

_____

Do you track your nutrition and/or exercise through a journal or phone app? ☐ Yes ☐ No

If yes, please describe._____

Do you find yourself preoccupied with food? ☐ Yes ☐ No

If yes, explain. _____

Please list any non-medical dietary limitations you have (dislikes or cultural, religious/ethnic preferences):

_____

_____

Do you have any specific food rules or rituals you follow? ☐ Yes ☐ No

If yes, please explain. _____

Do you have food cravings? ☐ Yes ☐ No

If yes, do food cravings generally happen at specific times in the day or related to specific situations, or are they more general? Please explain.

_____

Please list any limitations related to time, budget, food shopping experience, or kitchen constraints:

_____

_____

_____

Do you make yourself sick or use laxatives if you feel you have eaten too much or are uncomfortably full? __Yes__No
If yes, how often does this happen? _____

Do you ever binge eat? ☐ **Yes** ☐ **No** **If yes, how often does this happen?** _____

If yes, what constitutes a binge for you?

_____

Do you ever worry that you have lost control over how much you eat? ☐ **Yes** ☐ **No**

Please list any stressors that you feel impact how you eat:

_____

_____

Please list any additional social or environmental factors that you feel impact how you eat:

_____

On average, how many hours of sleep do you get per day on weekdays? _____ **Weekends?** _____

Please describe your typical exercise habits.

Type of Exercise	Days per Week	Duration of Exercise

Does your eating or feelings about your body change when you miss a workout? ☐ **Yes** ☐ **No**

If yes, please explain _____

How often do you have a **drink containing alcohol?

☐ Never ☐ Monthly or less ☐ 2-4 times per month ☐ 2-3 times per week ☐ 4 or more times per week

How many standard drinks containing alcohol do you have on a typical day?

☐ 1-2 ☐ 3-4 ☐ 5-6 ☐ 7-9 ☐ 10 or more

How often do you have more than six drink on one occasion?

☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily

***1 drink is equal to: 12 ounces of beer (usually 1 can or bottle), 5 ounces of wine (1 standard wine glass) or 1.5 ounces of liquor (straight or mixed in a drink). Keep in mind some drinks such as a Long Island Ice Tea have 4 servings of liquor in one glass making it equal to 4 standard drinks.*

Nutrition and Digestive Health

Circle any of the symptoms below that you experience frequently:							
Heartburn	☐	Gas	☐	Bloating	☐	Stomach Pains	☐
Nausea/Vomiting	☐	Diarrhea	☐	Constipation	☐		

Do you have any known food allergies or sensitivities? ☐ **Yes** ☐ **No**

Do you associate digestive symptoms or other health issues with eating certain foods? ☐ Yes ☐ No

Please list any foods related to the previous digestive or allergy issues, and describe your body's reaction.

_____

_____

Weight History

Height: _____ Current Weight: _____

How often do you weight yourself? _____

Would you like to be weighed today ☐ Yes ☐ No

Desired Body Weight _____ Highest Weight_____ When? _____

Lowest Weight _____ When?_____ Weight 6 months ago_____

Have you had any recent changes in your weight that you are concerned about? ☐ Yes ☐ No

If yes, please explain: _____

Does your weight affect the way you think about yourself? ☐ Yes ☐ No

If so, in what way? _____

Are you preoccupied with being thinner or with thoughts of having fat on your body? ☐ Yes ☐ No

If yes, please explain. _____

For females:

	Yes	No
Do you have a regular menstrual cycle?	☐	☐
Have you ever lost your period for 3 months or more (not related to pregnancy)?	☐	☐
Do you take oral contraceptives?	☐	☐

Additional Information

Please circle the phrases that describe you.					
☐ fast eater	☐ erratic eater	☐ emotional eater (stressed, bored, sad, etc.)	☐ late-night eater	☐ dislike healthy foods	☐ eating on the road (travel)
lack of planning meals/menu ☐	rely on convenience foods ☐	family/roommates/friends ☐ have different tastes	love to eat ☐	eat too much ☐	☐ eat because I have to
negative relationship ☐ with food	struggle with eating issues ☐	☐ confused about food/nutrition	frequently eat ☐ fast food	poor snacking ☐ choices	too busy to think ☐ about health/nutrition

The food/nutrition questions I would like to make sure to ask are:

_____

_____

_____

_____