Kiwi Nutrition Counseling

Initial Nutrition Assessment Form

(Please complete the form below)

Client Name:_____

Date:_____

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

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

    1.

    2.

    3.

    3. Circle 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: _____

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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?(Circle 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 (circle)? Yes No

6. What obstacles have you faced or might you face when trying to improve your diet (circle 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. How many meals do you eat per day? _____

8. How many snacks do you eat per day? _____

9. How many days a week do you eat fruit (circle)?

   Every day 5 days/wk 3days/wk 1-2days/wk Never

10. How many days a week do you eat vegetables (circle)?

    Everyday 5days/wk 3days/wk 1-2days/wk Never

11. Do you smoke (circle)? Yes No If yes, how many cigarettes/cigars per day? ___

12. Do you drink alcohol (circle)? Yes No

    If yes, how often do you consume alcohol (circle)?

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Daily A few times per week A few times per month

13. How often do you drink coffee (circle)?

Never 1 cup/day 2-3 cups/day 4 or more cups/day

14. How often do you consume soda or sweetened beverages like tea or lemonade (circle)?

Never daily A few times per week A few times per month

15. Do you often overeat (circle)? Yes No

If Yes, how often and why?

_____

_____

16. What types of food do you typically crave (circle)?

a. Sweets/desserts
b. Chocolate
c. Bread/pasta
d. Fried foods/salty foods
e. Dairy
f. Meats
g. Alcoholic beverages

17. Do you experience any of the following if you haven't eaten in a while (circle)?

Irritability lightheadedness weakness

18. How often do you eat at home/cook your own meals (circle)?

All meals 1-2/day 1/day rarely

19. Who does the cooking/food shopping? _____

20. How often do you have bowel movements (circle)?

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3+/day 1-2/day every other day once a week or less

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

22. The condition of your skin and hair is (circle):
    Very dry dry normal oily

23. Please rate your energy level (circle):
    Excellent Good Fair Poor

24. How would you rate your quality of sleep (circle)?
    Excellent Good Fair Poor

    How many hours of sleep do you get per night? _____

25. Do you often wake up at night and eat (circle)? Yes No

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

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

28. Is there anything else you would like to share with your Dietitian?
    _____
    _____
    _____
    _____.

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Thank You!

Weight Questionnaire

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

1. **Describe your present weight (circle one):**

Very overweight/Obese Slightly overweight Healthy Weight Underweight

2. **How do you feel about the way you look at this weight (circle one)?**

Extremely unhappy Unhappy Neutral Happy Very happy

How much do you / did you weigh:
Now: _____
3 months ago: _____
6 months ago: _____
1 year ago: _____

Height: _____

3. **At what weight have you felt your best or do you think you would feel your best? _____**

4. **How much weight would you like to (circle)** Lose or Gain? _____

6. **Do you feel your weight affects your daily activities (circle one)?**

All the time Often Rarely Not at all

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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
□ Jenny Craig □ NutriSystem □ Doctor run weight loss □ Gym/Personal Trainer
□ Bariatric Surgery □ RD or nutritionist □ Other: _____

Thank You!

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: __Married __Divorced __Single __Other _____

Date of Birth: _____ Gender: __Male __ Female Social Security number: _____

Name of employer: _____Occupation: _____

Highest Level of Education: ___High School __Some College __College Degree __Graduate Degree

Emergency contact name: _____Telephone number: _____

Relationship of emergency contact to you: _____

Please list all your physicians that you see on a regular basis:

1.

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2.

3.

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: _____

What is your primary language?

_____

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