Nutrition Assessment Form

I. Identifying Information

Full Name: _____ *Today's Date* _____

Birth Date: ___/___/___ *Age:* ____ *Sex:* _____ *Grade level:* _____

Ethnicity: ☐ *Caucasian* ☐ *African American* ☐ *Hispanic* ☐ *Native American* ☐ *Asian American* ☐ *Other:* ____

Referring Clinician: _____

Reason(s) for visit: _____

II. Medical History ***(please circle one)***

Are you allergic to any food or drink? Yes or No

If yes, please specify: _____

Do you get a rash or edema from your allergy? Yes or No

Do you take any vitamins, minerals and/or food supplements? Yes or No

If yes, which ones _____

Have you had any major injuries, hospitalizations, or operations? Yes or No

If yes, what _____

Do you have any chronic illnesses? Yes or No

*If yes, please explain*_____

(Examples: Shortness of breath, Heartburn, Constipation, Excessive thirst, Headaches, High BP, ect)

Do you take any medications on a regular basis? Yes or No

*If yes, what medication and what dosage*_____

_____

Have you ever been diagnosed or do you suffer from anxiety? Yes or No

If yes, please explain _____

_____

Have you ever been diagnosed or do you suffer from depression? Yes or No

If yes, please explain _____

_____

Have you ever been diagnosed or do you suffer from an eating disorder, such as, anorexia, bulimia, or binge eating? Yes or No

If yes, please explain _____

_____

III. Family History

Do any family members have any of the following health conditions?

Health Conditions	***Circle the family member(s) with the health condition***					
Diabetes	*Mother*	*Father*	*Sibling*	*Grandparent*	*Aunt*	*Uncle*
Heart Disease/Heart Attack	*Mother*	*Father*	*Sibling*	*Grandparent*	*Aunt*	*Uncle*
High Blood Pressure	*Mother*	*Father*	*Sibling*	*Grandparent*	*Aunt*	*Uncle*
Obesity	*Mother*	*Father*	*Sibling*	*Grandparent*	*Aunt*	*Uncle*
Stroke	*Mother*	*Father*	*Sibling*	*Grandparent*	*Aunt*	*Uncle*
Eating Disorder	*Mother*	*Father*	*Sibling*	*Grandparent*	*Aunt*	*Uncle*

IV. Social History

Do you follow any special diet? Yes or No

If yes, are you compliant with this diet? Yes or No

If yes, what is the special restrictions/type of diet? _____

What type of milk do you consume? _____ *How much?* _____*# fl/oz/day*

(Skim, 1%, 2%, whole)

What else do you drink during the day? _____

Do you eat fruits? Yes or No

If yes, how often? _____*/day* _____*/week*

Do you eat vegetables? Yes or No

If yes, how often? _____*/day* _____*/week*

How many meals do you eat during the day? _____

Do you skip meal? Yes or No

If yes, which meals and why? _____

Are you physically active? Yes or No

If yes, include time, day, duration and type? _____

How often do you go to "Fast food restaurants?" _____*/week*

What do you usually order? _____

_____

How often do you consume candy, sweets, processed snacks, and soda pop? _____*/week*

What are your special food likes and dislikes? _____

_____

Please describe a "typical" day in terms of what you eat and drink at meals (B, L, D and snacks)

Breakfast:

_____

Lunch:

_____

Dinner:

_____

Snacks:

_____

Beverages:

_____

What, if any, concerns do you have about your appetite, feeding behavior and/or diet?
(Include any time prep issues, sleep pattern issues, stress, environmental issues, food availability, binge eating, poor appetite etc...)

_____

_____

_____

_____

V. Nutritional Information (STAFF COMPLETION)

Height: _____ inches _____ cm *Current Weight: _____ lbs _____ kg*

BMI: _____ *UBW: _____ IBW: _____ % IBW: _____*
(Body Mass Index based on height/weight) *(+/- 10%)*

If weight change (indicate lbs/days, weeks, months):_____

Growth Chart for Children:
Height for Weight: _____ percentile
Weight for Age: _____ percentile
Height for Age: _____percentile
Blood pressure: _____percentile

VI. Laboratory Data (completed by the RD - if applicable)

Serum Transferrin: _____
Significance: _____

Serum Glucose (norm: 70-110 mg/dL): _____
Significance: _____

Serum Triglyceride: _____
Significance: _____

Serum Cholesterol: (norm: <170): _____

HDL (good cholesterol) should be >35 *LDL (bad cholesterol) should be <110*
Significance: _____

Conclusion, Recommendations and Other Relevant Data

_____
_____
_____
_____

Clients Signature: _____ *Date:* _____

RD's Signature: _____ *Date:* _____