Rapid Nutrition Assessment Tool **Medical Record No. _____**

With verbal/written consent taken from client: Yes_____

Date Taken/Time:_____/_____

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1. Client Identification:

1.1.Name _____ Gender: M____ F ____ Others _____

1.2. Date of Birth: _____ Age: _____

1.3. Home Address: _____Telephone No. _____

Email Address: _____

1.4. Name of Family Physician: _____Contact No. _____

1.5. Primary Contact Person: _____ Contact No. _____

1.6. Reasons for Referral to RD: _____

2. Subjective Data:

2.1.Medical and Family History:

2.2. Medical signs/symptoms/chief Complaints/Illness?_____

-Diarrhea/vomiting/constipation/pain/chewing/swallowing/dentition

_____

-Chronic disease/infection/physiological/mental changes/hospitalized

_____

-Family related medical risks/history/HTN/CVD/Diabetes/Cancer/etc.

_____

-COVID 19 related symptoms_____Complete vaccination_____

-Other medical consideration/history_____

2.3. Socio-Economic History: Occupation_____

-No. of Household members____. Physical activities/shopping/cooking

-Cultural/Religious preferences in foods_____

-Smoking/alcohol/recreation drugs/other situations _____

2.4. Physical/ Clinical Nutrition History:

-General appearance/paleness/sign of dehydration/skin/edema

-Muscle loss, gum/lip/sore throat/eyes/appetite/wound/swallowing/denture

-Any complaints related to food/eating_____

2. 5. Nutrition and Diet History:

- Food allergy_____/foods like/dislike_____

-Who does the cooking_____/How often do you eat outside_____

-What usual foods you eat ?_____

- What particular food belief/practices_____

- How much water/fluids you drink a day?_____

- **Food Frequency Recall : Most Common and usual foods consumed**

List all foods frequently consumed:_____

_____

_____

_____

_____

_____

_____

_____

-24 Hours food Recall:

-Wake up time/ What and how much food eaten from breakfast up to the time you sleep? Including drinks? Snacks?

Meal	Time	Food Items	Measurement	Remarks
Breakfast				
AM Snacks				
Lunch				
PM Snacks				
Dinner				
Evening Snacks				

3. Objective Data:

3.1. Laboratory Results: (Refer to laboratory results)

-FBG____/A1C ____/Sodium____/Potassium____/Total Cholesterol_____

-LLDL____/HDL____/Triglycerides____/Hemoglobin____/Creatine_____/

-eGfR_____. Other tests: _____

Note: _____

3.2. Medications: (Refer to lists for food and drug interaction)

-Food supplements/drug allergy/vitamins/minerals_____

_____

_____

Note: _____

3.3 Anthropomentric Data: Taken with verbal consent date/time_____

3.4. Actual Wt: _____Height_____BMI _____ IBW _____

- Usual Body Wt. _____Date taken_____ Percent Wt._____loss/gain

3.5. Did you lose weight in the past 3 months? _____

3.6. Did you reduce/increase food intake recently?_____

3.7. Waist Circumference:_____cm.; Hip ____cm.; W/H ratio_____

WC Below/Above Normal_____(102 cm. M- 88 cm. F) _____

W/H Ratio below/above Normal _____(0.8 F-1.0 M)_____

4. Nutrition Assessment and Diagnosis based on the information gathered:

4.1. TER/ Calorie Needs:_____Carbohydrates(gm.)_____

Protein(gm.)_____ Fats (gm) _____Fluids (ml.)_____

4.2Basis of Dietary Computation: _____

4.3.PES Statement: _____

_____

-Note: _____ _____

5. Planned Goals and Objectives set with the clients consent/ participation:

5.1.Long Term Goals:_____

_____

5.2. Short Term Goals: _____

_____

5.3. Client plans/: _____

_____

_____

5.4. Recommendations:_____

_____

_____

6. Client Education and Instructions: (Topics /Materials Given)

6.1. Topics /Materials Given_____

_____

6.2.Client other issues/readiness: _____

_____

6.3. Weight monitoring/ Problems encountered/Support/Referral/

_____

6.4. General health improvement/concern_____

_____

7. Plan for Follow-up: _____

_____

7.1. Return visit/Date/Time_____

8. Name/ Signature of RD: _____

Date/Time_____