Client Assessment Questionnaire

DEMOGRAPHIC DATA

Name _____ Date: _____

Address _____ Home telephone: _____

E-mail _____ Cell telephone: _____

Gender: M F

Age: _____ Birth date _____ Height _____ Weight _____

HEALTH HISTORY

1. What medical concerns (e.g., pregnancy), if any, do you have at the present time?

_____

2. Indicate whether you have had blood relatives with any of the following problems:

Cancer	☐ yes	☐ no	High blood pressure	☐ yes	☐ no
Diabetes	☐ yes	☐ no	Osteoporosis	☐ yes	☐ no
Heart disease	☐ yes	☐ no	Thyroid disorder	☐ yes	☐ no
High cholesterol	☐ yes	☐ no			

3. Do you have complaints about any of the following?

____ Appetite	____ Constipation	____ Menstrual difficulties
____ Bleeding gums	____ Diarrhea	____ Seeing in dim light
____ Bruising	____ Edema	____ Sudden weight change
____ Chewing or swallowing	____ Indigestion	____ Stress

4. Do you use tobacco in any way? ☐ yes ☐ no

How much? _____

Did you recently stop smoking? ☐ yes ☐ no

5. List any food allergies or intolerances.

_____

_____

_____

_____

_____

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DRUG HISTORY

List any prescribed, over-the-counter, herbal, or vitamin/mineral supplements you take.

_____

_____

_____

DIET HISTORY

1. Do you follow a special dietary plan, such as low cholesterol, kosher, or vegetarian?

   _____

2. Have you ever followed a special diet? ☐ yes ☐ no Explain: _____

3. Do you have any problems purchasing foods that you want to buy? ☐ yes ☐ no

4. Are there certain foods that you do not eat? _____

5. Do you eat at regular times each day? ☐ yes ☐ no How often? _____

6. Identify any foods you particularly like. _____

7. Do you drink alcohol? ☐ yes ☐ no How often? _____

8. What change would you like to make?

   ☐ Improve my eating habits
   ☐ Improve my activity level
   ☐ Learn to manage my weight
   ☐ Improve my cholesterol/triglyceride levels
   ☐ Other _____

9. Please add any additional information you feel may be relevant to understanding your nutritional health.

   _____

10. To tailor your counseling experience to your needs, it would be useful to know your expectations. Please check one of the following to indicate the amount of structure you believe meets your needs:

    ☐ *Just tell me exactly what to eat for all my meals and snacks.* I want a detailed food plan. Example: ¾ cup raisin bran, 1 cup skim milk, 1 small orange, 1 slice whole wheat toast, 1 teaspoon margarine

    ☐ *I want some structure and freedom to select foods. I want to use a food group plan.* Example: 1 serving of dairy foods, fruits, and fat and oil group; 2 servings of grains

    ☐ *I don't want a diet. I just want to eat better. I will just set food goals each week.*

SOCIOECONOMIC HISTORY

1. Circle the last year of school attended:

1 2 3 4 5 6 7 8 Grade School | 9 10 11 12 High School | 1 2 3 4 College | M.A. | Ph.D.

Other type of school _____

2. Are you employed? _____ Occupation _____

3. How many people in your household? _____ Ages _____

4. Present marital status (circle one):

Single Married Divorced Widowed Separated Engaged

5. Do you have a refrigerator? _____ Stove? _____

6. Who prepares most of the meals in your home? _____ Shopping? _____

7. Do you use convenience foods daily? ☐ yes ☐ no

8. How often do you eat out? _____ Where? _____

9. Have you made any food changes in your life you feel good about? ☐ yes ☐ no

10. Who could support and encourage you to make these changes? _____

PHYSICAL ACTIVITY HISTORY

1. Do you currently participate in regular physical activity? ☐ yes ☐ no

(If no, go to question #3)

2. Describe your current physical activity habits by completing the table below.

a) List all of the physical activities you do in a typical week in the top row.

b) For each activity, list how many days each week you engage in the activity.

c) On the days you do the activity, what are the total minutes in the day that you are involved in the activity?

d) How hard do you perform the activity:

- Light – equal to a strolling walk; easy to talk
- Moderate – equal to a brisk walk; heart rate and breathing increases slightly; you can talk but could not sing
- Vigorous – equal to a slow jog or more; heart rate and breathing increases significantly

Type of Physical Activity	**Sample: Walking**					
Number of days/week	3					
Minutes per day	15					
Total minutes per week	45					
Intensity	moderate					

3. How much time each day do you spend sitting, reclining, or napping? Include time sitting at a desk and in meetings, working on a computer, watching TV and movies, playing video games, and commuting. Do not count the time you spend sleeping during your usual sleep hours.

hours per day _____

EDUCATION INTERESTS

What information would you like from your counselor?

☐ Supermarket shopping tour
☐ Weight management
☐ Healthy food preparation
☐ Fiber
☐ Food labels
☐ Eating out
☐ Portion size
☐ Eating less fat
☐ Walking program
☐ Other _____
☐ Exercise
☐ Alcohol calories
☐ Meal planning
☐ Snack foods

Thank you for your willingness to share this information and to take part in the Nutrition Clinic. We look forward to working with you to make lifestyle changes to meet your food and fitness objectives.