AMERICAN COLLEGE OF Lifestyle Medicine

LOMA LINDA UNIVERSITY HEALTH

Produced in collaboration with Loma Linda University

Nutrition Assessment

GETTING STARTED

		Very poor health										Excellent health
a.	Please circle your current overall **LEVEL OF HEALTH**.	0	1	2	3	4	5	6	7	8	9	10

b. Please rank the top **3 areas** you would like to improve with 1 being the most important and 3 the least important.

Sleep _____ Weight Management _____ Nutrition _____

Exercise _____ Purpose & Connection _____ Mental Health _____

Substance Use _____

		Not important at all										Very important
c.	How **IMPORTANT** is it for you to make the change you ranked as the **#1** most motivated topic area to address?	0	1	2	3	4	5	6	7	8	9	10
d.	How **CONFIDENT** are you regarding your ability to make the change you ranked as the **#1** most motivated topic area to address?	0	1	2	3	4	5	6	7	8	9	10
e.	How **IMPORTANT** is it for you to make the change you ranked as the **#2** most motivated topic area to address?	0	1	2	3	4	5	6	7	8	9	10
f.	How **CONFIDENT** are you regarding your ability to make the change you ranked as the **#2** most motivated topic area to address?	0	1	2	3	4	5	6	7	8	9	10
g.	How **IMPORTANT** is it for you to make the change you ranked as the **#3** most motivated topic area to address?	0	1	2	3	4	5	6	7	8	9	10
h.	How **CONFIDENT** are you regarding your ability to make the change you ranked as the **#3** most motivated topic area to address?	0	1	2	3	4	5	6	7	8	9	10

i. **What would you like to gain from this lifestyle visit?** *Check all that apply*

☐ More medical/scientific knowledge ☐ Practical health tips ☐ Other: _____

☐ Accountability ☐ Personalized plan

Patient Name:_____ DOB: _____

The 4Leaf Survey

For estimating the percent of your calories from whole plants

As you know, 4Leaf for Life was designed to help people everywhere leverage the simple, yet powerful, concept of maximizing the percentage of their calories from whole, plant-based foods — still in nature's package. This survey identifies your current 4Leaf "level" of eating. Note that even the 1-Leaf level is in the top 10% — when if comes to healthy eating. These 12 questions will give you a pretty good idea of how you can improve your score.

The 4Leaf Survey

Take 2 minutes, be honest, circle your answers and tally your score. (A serving = about 1/4 of a plate)

1	**FRESH FRUIT.** On average, how many daily servings of whole fresh fruit do you eat? (Fruit juice doesn't count; not a whole plant)	0	1-2	3-5	6+
2	**WHOLE VEGETABLES.** On average, how many daily servings of whole vegetables do you eat?	0	1-2	3-5	6+
3	**WHOLE GRAINS, LEGUMES, POTATOES** or other starches. On average, how many daily servings of these foods do you eat?	0	1-2	3-5	6+
4	**OMEGA-3s.** Are you getting all you need from whole, plant-based sources like flaxseeds, walnuts, hemp & chia seeds?	No	Maybe	Not Sure	Yes
5	**DAIRY FOODS.** How many days per week do you eat dairy foods like cheese, yogurt and ice cream? (Soy does not count)	0	1-2	3-5	6-7
6	**EGGS.** How many days per week do you either eat eggs or add them as an ingredient when cooking?	0	1-2	3-5	6-7
7	**COW'S MILK OR CREAM.** How many days per week do you drink them or add to your food, like cereal, coffee, etc.?	0	1-2	3-5	6-7
8	**ADDED SUGAR.** Are you really serious about eliminating added sugar at home and in food products that you buy?	You bet	Fairly	Not Very	No
9	**WHITE FLOUR.** Bread, pasta, cakes, cookies, etc. How would you describe your consumption level of these foods.	Zero	Light	Medium	Heavy
10	**SWEETS & SALTY SNACKS.** How would you best describe your consumption level of these unhealthy foods.	Minimal	Light	Medium	Heavy
11	**MEAT, POULTRY AND FISH.** How many of your meals per week include any animal flesh? (beef, pork, lamb, chicken, turkey or fish)	0-1	2-5	6-11	12+
12	**VEGETABLE OIL.** How many of your meals per week include vegetable oil, like olive or canola? (All oil is 100% fat, not whole plant)	0-1	2-5	6-11	12+

Patient Name:_____ DOB: _____

NUTRITION

EATING PATTERNS

Please answer based on your typical eating habits

a. On average, how many cups (8 oz.) of caffeinated beverages do you drink **per day** (tea, soda, coffee, or energy drinks)? 0 1 2 3 4+

b. On average, how many servings of alcohol do you drink **per day**? 0 1 2 3 4+

c. On average, how many cups (8 oz.) of sugary drinks (soda, sports drinks, juice) do you drink **per day**? 0 1 2 3 4+

d. On average, how often do you snack on convenience or "junk" food **per day**? (i.e. chips, candy, granola bars, crackers, cookies, etc.) 0 1 2 3 4+

e. On average, how many meals do you buy from a restaurant or fast food **per week**? 0 1 2 3 4+

f. On average, do you drink at least 8 glasses of water **per day**? No Yes

g. On average, do you eat at least 5 handfuls of nuts **per week**? No Yes

h. Do you use natural or artificial sweeteners? (i.e. Equal, Stevia, Splenda, Sweet & Low, honey, agave, etc.) No Yes

i. Do you add salt to most of your meals? No Yes

j. Do you eat processed meats (i.e. sausage, hot dogs, salami, bacon)? No Yes

k. Do you have any bad reactions (sensitivities or allergies) to food? If yes, please list here: _____

l. Do you avoid any particular foods? If yes, please list here: _____

m. Do you have foods that you crave? If yes, please list here: _____

n. Are you currently following a particular diet or nutrition plan? If yes, please list here: _____

o. During the last 3 months, did you have any episodes of excessive overeating? If yes please explain here: _____

p. Are you concerned about making the wrong food choices? If yes, please explain here: _____

q. Have you ever had an eating disorder? If yes, please list here: _____

Do you use any of the following VITAMINS or SUPPLEMENTS? ***Check all that apply***

❑ Vitamin D ❑ Calcium ❑ Vitamin B12
❑ Probiotics ❑ Omega 3 ❑ Multivitamin
Other: _____

Do you use any of the following OILS with your meals or cooking? ***Check all that apply***

❑ Olive Oil ❑ Canola Oil ❑ Vegetable Oil
❑ Coconut Oil ❑ Butter ❑ Lard
Other: _____

FOOD RECALL: ***Please record below what AND how much you ate and drank yesterday (or the last typical day)***

Breakfast: _____
_____ Time: _____

Lunch: _____
_____ Time: _____

Dinner: _____
_____ Time: _____

Snacks: _____
_____ Time: _____

Drinks/Beverages: _____
_____ Time: _____

Patient Name:_____ DOB: _____

WEIGHT MANAGEMENT

BEHAVIOR PATTERNS	Never	Seldom	Sometimes	Often	Always
a. How often do you skip meals?	1	2	3	4	5
b. How often do you snack in between meals?	1	2	3	4	5
c. How often do you eat while watching TV?	1	2	3	4	5
d. How often do you eat while in bed?	1	2	3	4	5
e. How often do you have difficulty sleeping?	1	2	3	4	5
f. How often do you lack physical activity or exercise?	1	2	3	4	5
g. How often do you feel a lack of purpose or meaning in your life?	1	2	3	4	5

Which of the following factors apply to your eating habits and current lifestyle? ***Check all that apply***

❑ Like healthy food	❑ Don't like healthy food	❑ Know how to cook healthy foods
❑ Fast eater	❑ Eat slowly	❑ Read nutrition labels
❑ Rely on packaged or fast foods	❑ Dislike cooking	❑ Prepare meals at home
❑ Do not plan meals	❑ Eat a variety of foods	❑ Always hungry
❑ Late night eater	❑ Negative relationship to food	❑ Erratic eater
❑ No time to prepare healthy food choices	❑ Don't know how to cook	❑ Live alone or eat alone often

Do any of the following situations or emotions cause you to eat? ***Check all that apply***

❑ Sadness	❑ Pain	❑ Insomnia	❑ Anxiety
❑ Fatigue	❑ Social or Family Situations	❑ Boredom	❑ Stress

Patient Name:_____ DOB: _____

WEIGHT MANAGEMENT (continued)

WEIGHT HISTORY

a.	Have you ever been overweight or obese? If yes, answer below:	No	Yes
	Were you overweight as a child?	No	Yes
	Were you overweight as a teenager?	No	Yes
	Were you overweight between the ages of 20-29?	No	Yes
	Were you overweight between the ages of 30-39?	No	Yes
	Were you overweight above the age of 40?	No	Yes
b.	Are you currently trying to lose or gain weight?	No	Yes
	If yes, please circle your goal: Lose weight Gain weight		
c.	Have you ever intentionally lost or reduced your weight by more than 5 lbs.?	No	Yes
	If yes, did you regain weight within 1 year?	No	Yes
d.	Have you had weight loss surgery?	No	Yes

If yes, please list the type of surgery you had: _____

Have you ever used weight loss medications? ***If yes, circle which ones you have used? If other, please list.***

❑ Acutrim	❑ Alli	❑ Amphetamines	❑ Anorex	❑ Belviq	❑ Byetta	❑ Contrave
❑ Dexatrim	❑ Didrex	❑ Fastin	❑ Fenfluramine	❑ Mazanor	❑ Meridia	❑ Obalan
❑ Phendiet	❑ Fen-Phen	❑ Phentermine	❑ Plegine	❑ Plegine	❑ Prozac	❑ Pondimin
❑ Qsymia	❑ Redux	❑ Sanorex	❑ Tenuate	❑ Tepanol	❑ Vyvanse	❑ Wechless
❑ Wellbutrin	❑ Xenical	❑ I don't remember the name of the medication				

❑ Other _____

WEIGHT LOSS STATEGIES

Have you tried any of the following alternative therapies or programs? ***Check all that apply. If other, please list.***

❑ Acupuncture	❑ Acupressure	❑ Nutritionist/Registered Dietitian
❑ Residential Programs	❑ Hypnosis	❑ Physical Activity/Exercises

❑ Other _____

Which commercial or fad diets have you tried in the past? ***Check all that apply. If other, please list.***

❑ Atkins Diet	❑ Low Fat	❑ Calorie Counting	❑ Paleo
❑ CHIP	❑ South Beach	❑ DASH	❑ Vegan
❑ Mediterranean Diet	❑ Elimination Diet (Allergy)	❑ Gluten Free	❑ Vegetarian
❑ Jenny Craig	❑ Weight Watchers	❑ Low Carb	❑ Slim Fast/Meal Replacement

❑ Other _____

Patient Name:_____ DOB: _____