Initial Nutrition Assessment Form

(Please complete the form below)

Client Name:_____

Date:_____

1. Please briefly explain your reason for seeing a Nutrition Consultant 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. Weigh loss
c. Increased energy
d. Improved health (ie: blood glucose, cholesterol levels, blood pressure)
e. Improved Athletic performance
f. Prevention of disease I am at risk for
g. Other:

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 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)?_____

Everyday 5days/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)?

Daily A few times per week A few times per month

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

Never 1cup/daily 2-3cup/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 a week A few times per month

15. Do you often over eat (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)?

3x/day 1-2x/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 is your method of exercise?

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

_____

_____

_____

28. Is there anything else that has come to your mind that you would like to share?

_____

_____

_____