NUTRITION COUNSELING
INITIAL ASSESSMENT

NAME_________________________________ **Today's Date** ________________________

DATE OF BIRTH ________________________

CONTACT INFORMATION:

☐ Home Number ____________________ ☐ Cell phone number ________________________

☐ Work Number ____________________ ☐ Okay to call at work? ☐ No ☐ Yes

Answering machine ☐ No ☐ Yes ☐ Ok to leave message

☐ Your own personal Email Address (Optional) ______________________________________

Do you view your email messages at least 3 times per week**?** ☐ No ☐ Yes

Is it ok to communicate information via email/voicemail ☐ No ☐ Yes

If yes, please sign: Signature: _________________________________**Date**________________

RACE / ETHNICITY

☐ White / Caucasian ☐ Black / African American ☐ Native American ☐ Middle Eastern

☐ Asian / Chinese / Japanese / Korean / Pacific Islander ☐ Eastern European

☐ Hispanic / Cuban / Mexican / Puerto Rican / Latino

EMPLOYMENT / EDUCATION

Presently Employed ☐ No ☐ Yes ☐ Retired year______ Type of Work: ☐ sedentary ☐ physical

Occupation: ____________________________Do you work shifts?________________________

Education: ☐ Some High School ☐ High School Diploma / GED

☐ Some College ☐ Technical School ☐ College Graduate

HEALTH CARE CONCERNS

Do you have financial concerns that may affect your health care? (Foods/Medications) ☐ No ☐ Yes

Who do you live with? ____________________________________Number in Household ________

Do you have family, friends or organizations you turn to for support? ☐ No ☐ Yes ________________

Are there any religious or ethnic concerns that may affect your health care? ☐ No ☐ Yes

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HEARING / VISION / WRITING

Do you have any difficulty with written information: ☐ No If Yes: ☐ reading ☐ writing ☐ understanding

Do you have difficulty with hearing? ☐ No ☐ Yes ____

Are there times when you have trouble seeing? ☐ No ☐ Yes ____________________________________

MEDICAL HISTORY (CHECK ALL THAT APPLY) ☐ None

☐ Family history of diabetes ☐ Diabetes during pregnancy

☐ High Blood Pressure ☐ Delivered baby weighing 9 or more pounds

☐ Elevated Cholesterol ☐ Thyroid Disease ☐ Arthritis

☐ Sleep Apnea ☐ Asthma ☐ Depression ☐ Emotional Problems

☐ Surgeries / Other ____

____

HEART / STROKE HISTORY: (INDICATE YEAR OF OCCURRENCE)

☐ Chest Pain __________ ☐ Heart Attack _________ ☐ Heart Surgery _________

☐ Heart Stents __________ ☐ Heart Failure _________ ☐ Stroke_________

ACUTE/ CHRONIC COMPLICATIONS (CHECK ALL THAT APPLY) ☐ **None**

☐ Frequent urination ☐ Gastrointestinal problems (constipation, diarrhea, bloating)

☐ Frequent tiredness ☐ Skin problems (dry, scaly, slow healing)

☐ More thirsty than usual ☐ Kidney problems / bladder infections

☐ Numbness or tingling in hands/feet ☐ Pain in legs during or after walking

☐ Eye Problems: ☐ cataracts ☐ macular degeneration ☐ glaucoma ☐ retinopathy

PHYSICAL ACTIVITY

Are you medically allowed to exercise? ☐ No ☐ Yes ; If NO, what are your restrictions_______________

How often do you exercise? Number of times per week _____ Number of minutes each time __________

What kind of exercise do you do? ____

☐ Inactive ☐ Housework / Yardwork ☐ Walking ☐ Strength Training (Weights / Bands) ☐ Gym

☐ Unable to exercise due to physical limitations: ____

Participant Name: ____

NUTRITION COUNSELING
INITIAL ASSESSMENT

ALLERGIES

Drug Allergies: ☐ None ______________________________ ☐ Reaction: _________________________

Food Allergies / Intolerances: ☐ None ___________________ ☐ Reaction __________________________

ALCOHOL USE:

☐ Never ☐ Daily ☐ Occasionally ☐ Weekly ☐ I have a problem with alcohol.

Number of Drinks per day ___________ per week __________ per month ____________________

Type of Alcohol: ____

TOBACCO USE

Type: ☐ None ☐ Cigarettes ☐ Cigar ☐ Pipe ☐ Chew / Dip ☐ Other: __________________________

Packs smoked per day: ______________ Number of years smoked: ________________________________

Are you ready to set a Quit Date? ☐ No ☐ Yes – Quit Date ____________________________________

Do you currently live with anyone who uses tobacco? ☐ No ☐ Yes

I would like assistance with Smoking / Tobacco Cessation? ☐ No ☐ Yes

MEDICATIONS: Please answer the questions below or you may bring a list of your medications. Include name, dose, and time(s) of day you take the medication(s).

☐ **None** ____

____

____

____

VITAMINS / SUPPLEMENTS : ____

How often do you miss or skip any of your medications? ☐ Sometimes ☐ Rarely/Never

PREGNANCY: IF APPLICABLE

Pre pregnancy weight:_________ Last Menstrual Period __________Number of weeks pregnant:_________
Expected due date: ____________ Where do you plan to deliver?________________

Do you plan to breastfeed? ☐ No ; ☐ Yes ; ☐Unsure

Were you a smoker prior to pregnancy? ☐ No ☐ Yes

Participant Name: ____

NUTRITION COUNSELING/ INITIAL ASSESSMENT

In your own words, why are you seeing the Dietitian? ____
____

Explain any previous diet education ____

EATING HABITS: Typical Meal Pattern

☐ Breakfast, Lunch, Dinner ☐ 2 meals / day ☐ No set pattern ☐ Eat whenever I am hungry

Snack Time(s): ☐ None ☐ Between Meals ☐ Bedtime ☐ Eat throughout the day

Do you skip Meals? ☐ No ☐ Yes ----- ☐ Daily ☐ Weekly ☐ Infrequently.

Number of meals eaten in **restaurants** per week is: _______Type is mostly: ☐ fast food ☐ *not* fast food

Who plans/prepares meals? ☐Self ☐Spouse ☐other: _________________________

HOW OFTEN DO YOU EAT THE FOOD GROUPS LISTED BELOW?
Select one: Never= 0 Occasionally=1 Daily=2 Several times a day=3

Fruits: _____ Vegetables: ____ Meat, fish, chicken, cheese, other Protein foods, etc: _____

Starchy foods, such as bread, cereal, pasta, beans, cracker, etc. _____ Milk, yogurt: _____

Fatty foods, fried foods, gravy, salad dressing: ____ Sweetened beverages/soda pop: _____

Sugar, Honey, Cookies, ice cream, desserts, sweets: _____

How would you rate your **Portion** control: ☐ I eat too little; ☐ Just Right; ☐ I eat too much

WEIGHT HISTORY:

Highest weight _______ in what year? _________; Lowest weight_______ in what year?___________

Over the past year, has your weight changed? ☐gained; or ☐lost ; by how much? ________pounds

Current Height__________ Weight__________ Goal Weight____________

READINESS TO CHANGE:

Your past **success rate** at changing your behaviors for the better is: ☐ poor ☐ fair ☐ good ☐ very good

Rate the "Readiness" you now have to change your eating behaviors:
Circle one: none=1 low=3 moderate=5 high=7 very high=9-10

Rate the "Readiness" you now have to change your activity level:
Circle one: none=1 low=3 moderate=5 high=7 very high=9-10

***Bring a 3 day record of your food & beverage intake; include time of day and amounts.**

Participant Name: ____