Nutrition Assessment Form

Name: **Date:** **Birth date:**
Phone (W) **(C)** **(H)** **Fax**
Email Address: **Home Address:**

Anthropometric Data: (Office Use) Age: HT: WT: Goal Wt. UBW: IBW:
Recent wt: changes: BEE: TDE: BMI: BP: Resting HR: BF%

Weight Loss Goals and History

How much weight do you want to lose?

__ 5-10 lbs. __ 10-20 lbs. __ 20-30 lbs. __ 30-40 lbs. __40-50 lbs. __ 50-70 lbs. __70-100 lbs. __over 100 lbs.

What would you consider your ideal weight to be?_______ lbs.

In your own words, would you describe your body as: __ loose __ flabby __ skinny __ toned __ strong __ other:______________________

Do you gain weight easily? _____ Lose weight easily? _____

Do you usually regain the weight you have lost on a diet? ___________

How long have you kept the weight off, after having lost it?

__1 month __ 2 months __3-6 months __6-12 months __ over a year.

Do other members of your family have a weight problem? __________

When did you start to gain weight?

__Before age 5 __ Between 10-20 __Between 20-30 __ Over 30 __After menopause

Give a timeline of weight fluctuations:

Eating Habits

Check if you eat, drink or use:

__Alcohol __Coffee __Processed Meats __Refined sugars __Candy

__ Carbonated Beverages __Salt __Cigarettes __Fried Foods __Margarine

__ Saccharine (sweet & low) __ Chocolate

__Food Supplements (please list)__________________Medications:_________________

Describe your daily water intake:

__ 2-4 glasses __ 4-6 glasses __6-8 glasses __8-10 glasses __10 or more

What other liquids do you drink regularly?

__soda __diet sodas __coffee __ juices __ milk __tea __alcohol __ others

How many cups of coffee/tea/diet soda do you drink each day?

Do you monitor your salt intake? __yes __no

Do you conscientiously avoid foods with additives or preservatives? __yes __no

Do you feel “over-full” or uncomfortable after meals? __________

How many times do you eat each day *(including snacks)*?

__5-7 times __3-5 times__ 1-3 times __less than twice a daily

When do you eat your meals?__breakfast__ snack__ lunch__ snack__ dinner__

Where do you eat your meals?

Do you dine out often? Places?

Who prepares your food?

Who does the grocery shopping?

Have you ever followed a particular diet (Ex. Atkins, The Zone etc)? Was it successful? Why or why not?

List food like and dislikes:

Do you eat breakfast?

When do you usually eat your last meal? __3-6pm __6-9pm __9-12am __after midnight

Do you ever eat in the middle of the night? __yes __no

Are you hungry shortly after you eat? __yes __no __sometimes

Do you get sleepy during the day? __yes __no __sometimes

When? __8am- noon __1-4pm __4-8pm

How many hours of sleep do you get a night? __

When do you experience peak energy levels? __8am-noon __ 12-5pm __after 5pm

When do you experience your lowest energy levels? __8am-noon __ 12-5pm __after 5pm

Do you ever get shaky? __yes __no

What do you eat before working out? __

What do you eat after working out? __

What foods do you crave? __fats __sugars __chocolate __salts __alcohol __bread __pastry __dairy _carbohydrates

Do you use condiments? ___ketchup ___mayonnaise ___dressing ___sauces ___butter ___oils ___sugar/honey

Are you a compulsive eater/extremist or will a little treat keep you satisfied? __

Do you starve all day and binge at night? ___yes ___no ___sometimes

Do you have to eat out frequently for business reasons? ___yes ___no ___sometimes

Do you eat when you are: ___depressed ___stressed ___happy ___not hungry ___frustrated

How would you rate your metabolism? __sluggish ___slow ___medium ___fast

Do most meals at home consist of frozen or processed foods?
Are you a strict vegetarian? __yes __no

Do you celebrate with food? __yes __no __sometimes

Do you think of food as a reward? __yes __no __sometimes

Are you allergic to any of the following foods?___seafood (shrimp, shellfish, etc.)
___nuts___wheat or wheat products (pastas, breads, etc.) ___dairy (milk or eggs) ___grains
___corn___fruit ___sugars ___other:

How would you rate your overall knowledge of nutrition (1 poor-10 excellent) __
1 2 3 4 5 6 7 8 9 10

Circle the number that best describes the intensity of your symptoms.
0= Symptom is not present 1= Mild 2= Moderate 3= Severe

	Symptom				
1.	Burping	0	1	2	3
2.	Bloating	0	1	2	3
3.	Constipation	0	1	2	3
4.	Upset stomach	0	1	2	3
5.	Hard Stool	0	1	2	3
6.	Abdominal cramps	0	1	2	3
7.	Indigestion	0	1	2	3
8.	Poor appetite	0	1	2	3
9.	Pain in right side under rib cage	0	1	2	3
10.	Pain in left side under rib cage	0	1	2	3

Food frequency:

On average, how many servings do you eat a day?

Dairy 1 2 3 4 5 6 7 8 9 10 11 12

Bread, cereal, pasta 1 2 3 4 5 6 7 8 9 10 11 12

Fruit 1 2 3 4 5 6 7 8 9 10 11 12

Vegetable 1 2 3 4 5 6 7 8 9 10 11 12

Meat 1 2 3 4 5 6 7 8 9 10 11 12

Do you eat red meat? __yes __no __sometimes

Do you eat chicken? __yes __no __sometimes

Do you eat fish? __yes __no __sometimes

What kind of dairy do you eat?

Do you eat eggs? __yes __no __sometimes

What types of fruits do you like?

What types of veggies do you like?

What types of starches do you eat?

Exercise Habits

Are you following an exercise program?
Type:

Duration:

Frequency:
I
ntensity: (Scale of 1-10) _______ (1 being very low intensity; 10 being very high intensity)
Purpose of exercise: (Goals)

What time do you usually work out? ___6-9am ___9-12pm ___12-3pm ___3-6pm ___6-9pm

Do you stretch before working out? ___yes ___no ___sometimes

Do you own any exercise equipment? ___yes (Specify: _____________) ___no

Do you incorporate weights (resistance equipment) into your workout routine? ___yes ___no

What is your daily activity level? ___low ___moderate ___medium

___very active

What is your work schedule? ___part-time ___normal business hours ___intermittent employment ___homemaker __none

Do you practice yoga, pilates, cardio kickboxing, etc? __yes __no

Medical History - check all that apply:

__alcoholism
__anemia
__anorexia
__asthma
__bleeding gums
__blood pressure
high low
__breathlessness
__bulimia
__cancer
__chest pain
__cirrhosis, liver
__colitis
__concussion
__congenital defects
__congestive heart failure
__cough up blood
__depression
__dermatitis
__diabetes
__digestive disorders

__disk
__dizziness
__dry skin/hair/lips
__emphysema
__excessive thirst
__eye problems
__fainting frequently
__family history of diabetes
__family history of heart disease
__fatigue
__gingivitis
__goiter
__gout
__hair loss
__hearing loss
__heart pounds easily
__heart problems
__hepatitis
__herpes
__hyperlipidemia

__hypoglycemia
__insomnia
__jaundice
__kidney problems
__laxative addiction
__mononucleosis
__night blindness
__obesity
__phlebitis
__rapid mood swings
__retain water
__rheumatoid arthritis
__rigidity-muscle
__smoker
__stroke
__swollen joints
__thyroid disorder
__ulcer
__wound healing, poor
__other: _________

Goal Setting:

What is your biggest motivation for losing weight / transforming your life and body? Marriage? Upcoming class reunion? A recent divorce? Please explain.

How would you currently rate your motivation level?
(1 not motivated-10 extremely motivated)
1 2 3 4 5 6 7 8 9 10

Describe how you see yourself when you look in the mirror.

What are the barriers to achieving your goals?

What is your favorite part of your body, and why?

What is your LEAST favorite part of your body, and why?

Have you ever had plastic surgery? If so, where and why?

Do you consider yourself to be disciplined? Why or why not

How do you think your life would be different if you transformed your body?

Goal 1: (SMART)	**Short term (Date)**	**Long term (Date)**

Wt
Measurements
Dress or pant size
Body fat% change

Goal 2.

Goal 3.

What will you do to change these goals?
1.
2.
3.
List people who will support you and keep you motivated?
1.
2.
3.
When you lose the weight how do you want to feel? (Proud of your new shape, lighter, more energetic, free from obsessions over food and dieting etc)

How will you reward yourself once you achieved your goal