SCALES
NUTRITION & WELLNESS CENTER
Where EveryBody Matters.

Nutrition Assessment

Please complete this nutrition assessment form and bring it to your first session. Completing this form prior to our appointment will save time during the session and allow us to maximize our time together. Please call with any questions!

Date:_____

Name:_____ Date of birth:_____

Address:_____

Phone number: _____(day) _____ (evening)

Email address:_____

Referred by:_____

Primary MD:_____ Primary MD Phone:_____

Therapist:_____ Therapist phone:_____

What do you hope to accomplish through a consult with a registered dietitian?

_____

_____

_____

_____

Have you seen a registered dietitian in the past? ___Yes ___No
If yes, was it helpful? Why or why not?

_____

_____

_____

_____

What do you hope to accomplish during your first consult?

_____

_____

Do you have any concerns with your current weight or shape? ___Yes ____No
If yes, what are your concerns?

_____

_____

_____

_____

Do you have any concerns with your eating habits? ___Yes ___No
If yes, what are your concerns?

_____

_____

_____

_____

List all the diets you have tried including commercial diet programs, diets written about in books, and those that you have developed yourself and indicate your age at the time. Give a brief description of each diet.

Diet or program Age Brief description

_____

_____

_____

_____

_____

Are there any foods you avoid currently? ___ Yes ___No If yes, please list below:

_____ For what reason? _____

_____ For what reason? _____

_____ For what reason? _____

_____ For what reason? _____

_____ For what reason? _____

Do you have any food allergies or intolerances? ____Yes____No
If yes, please list and explain:

_____

_____

_____

How much alcohol do you drink in one week? _____

How many cups of caffeine-containing beverages do you drink daily? _____

Do you currently smoke? ___Yes___No

If yes, how many cigarettes do you smoke per day?_____

If no, have you ever smoked?____Yes____No If yes, when did you quit?_____

Do you take any vitamin, nutritional, or herbal supplements? ___Yes ____No
If yes, please list each supplement and dose:

_____

_____

_____

_____

Do you skip meals? ___Yes___No If yes, which meals do you skip and how often?

_____

_____

_____

Diet Recall: Please list everything you ate and drank from the time you woke up yesterday.
Time food/beverage and amounts:

Would you consider this a typical day? __Yes ___No If no, why not?

_____

_____

Please provide an example of eating on weekend day if recall was a weekday, or please provide a weekday if recall was a weekend.

Time, food/beverage, and amounts:

What would you consider a "good day" of eating?

Time, food/beverage, and amounts:

What would you consider a "bad day" of eating?

Time, food/beverage, and amounts:

Within your household, who does most of the cooking? _____

Within your household, who does most of the grocery shopping? _____

Do you read nutrition labels? ___Yes ___No If yes, what do you look for?

_____

How many times per week do you eat at restaurants? _____

How many times per week do you eat at fast food restaurants?_____

Are you comfortable eating in restaurants? ____Yes ____No If no, why not?

_____

Do you count calories? ___Yes ___No If yes, why?

_____

Do you use diet pills? ___Yes ___No If yes, how often and what dose?

_____

Do you use laxatives? ___Yes ___No If yes, how often and what dose?

_____

Do you or have you ever made yourself vomit? ___Yes ___No If yes, how often?

_____

Do you binge eat? ___Yes ___No If yes, how often?

_____

Do you weigh yourself? ___Yes ___No If yes, how often?_____

Please describe what hunger feels like to you:

_____

_____

Please describe what fullness feels like to you:

_____

_____

How do you know when to stop eating?

_____

_____

Weight History

Height:_____

Current weight:_____

Weight 2 months ago:_____

Weight 6 months ago:_____

Weight 1 year ago:_____

Highest weight as an adult:_____ Age:_____

Lowest weight as an adult:_____Age:_____

Please explain any weight changes throughout your adult life.

_____

_____

_____

_____

How did you feel about your body in elementary school?

_____

Intermediate school?

_____

High School?

_____

College?

_____

After college?

_____

Please describe your exercise routine and/or amount of physical activity (type, frequency, time).

_____

_____

_____

_____

_____

Please circle how **confident** you are that you can change your eating behaviors.

NOT VERY CONFIDENT VERY CONFIDENT
1 2 3 4 5 6 7 8 9 10

Please circle how **motivated** your are to change your eating behaviors

NOT VERY MOTIVATED VERY MOTIVATED
1 2 3 4 5 6 7 8 9 10

Who is supportive of your efforts?

_____

_____

Please provide any additional information that would be helpful for the dietitian to know.

_____

_____

_____

_____

_____

_____

If you have questions, please contact Jennifer Barnoud, MS, RD by phone at (615) 724-0865 during office hours or by email at jennifer@scales-nutrition.com anytime.