NUTRITION ASSESSMENT FORM

Patient Name: _____ **DOB:**_____ **Date**:_____

To help us focus on your needs, please check all that you would like to know more about:
☐ Healthy eating ☐ Weight gain/loss ☐ Choosing the right size portions of food
☐ Getting and staying active ☐ Shopping and planning meals and snacks
☐ Other: _____

EATING HISTORY:
Have you ever met with a registered dietitian/nutritionist before?
☐ Yes ☐ No Specify:
_____
How would you describe your current appetite? _____
How many times per week do you eat out?
☐ 0-1 ☐ 2-4 ☐ 5-8 ☐ Every day (_____ times)
What restaurants do you eat at frequently: _____
Do you have food allergies? ☐ Yes ☐ No Specify: _____
Do you have any restrictions on foods? ☐ Yes ☐ No Specify: _____
Does your family eat meals together? ☐Yes ☐ No
Who decides what and when you eat? _____
Do you have trouble controlling how much you eat? ☐ Yes ☐ No
Do you ever eat because you are bored, upset, or unhappy? ☐ Yes ☐ No
Do you ever eat meals in front of the TV/iPad/phone? ☐ Yes ☐ No
Do you snack whenever you want to? ☐ Yes ☐ No

How often do you eat the following kinds of foods? *(please circle)*

VEGGIES	**Daily**	**____ times/week**	**Never**
GRAINS	**Daily**	**____ times/week**	**Never**
SODA/JUICE SPORT DRINK	**Daily**	**____ times/week**	**Never**

FRUIT	**Daily**	**____ times/week**	**Never**
DAIRY	**Daily**	**____ times/week**	**Never**
WATER	**Daily**	**____ times/week**	**Never**

PHYSICAL ACTIVITY:
What kind of physical activity do you get? ☐ None ☐ PE/recess ☐ Sports
☐ Other: _____
How many days a week are you physically active?
☐ None ☐ 1-2 ☐ 3-4 ☐ 5-6 ☐ more than 6
How many minutes are you physically active on these days?
☐ 16-30 mins ☐ 31-45 mins ☐ 46-60 mins ☐ more than 60 mins

SOCIAL HISTORY:

What grade are you in school? _____ Do you go to after school programs/care? ☐ Yes ☐ No
What is your usual sleep schedule? (bedtime – wake time) _____

As providers, we are concerned about the safety of our patients, so we ask everyone:
Is it difficult for you/your family to pay for food? ☐ Yes ☐ No
Do you feel safe at home? ☐ Yes ☐ No
Do you feel safe in your neighborhood? ☐ Yes ☐ No
How often are you feeling down, depressed, or hopeless?
☐ Not at All ☐ Sometimes ☐ Often ☐ All the Time
How often do you have little interest in things or activities?
☐ Not at All ☐ Sometimes ☐ Often ☐ All the Time

MEDICAL INFORMATION:
Medication Allergies: ☐ None ☐ Specify: _____
Medications, Vitamins, and Herbal Supplements:

NAME	DOSE + FREQUENCY	YEAR STARTED
Example: Vitamin D	2000 IU daily	2014

HEALTH HISTORY: *(Check all that apply)*
☐ High Cholesterol ☐ Hypertension ☐ Diabetes ☐ Thyroid Disease ☐ Asthma
☐ Upset stomach, nausea, vomiting, constipation, or diarrhea (circle all that apply)
☐ Other: _____
Does anyone in your family have diabetes? ☐ Yes ☐ No
Does anyone in your family have heart disease? ☐ Yes ☐ No

MENSTRUAL HEALTH *(if applicable):*
Have you started menses? ☐ Yes (age at onset ____) ☐ No
Having regular cycles ☐ Yes ☐ No ☐ other:
_____

TEENS *(if applicable):*
Tobacco/Drug Use: *(PLEASE CIRCLE: cigarettes, marijuana, alcohol, vapes, other:_____)*
☐ Never ☐ Former (quit _____ ago) ☐ Current (amount/day _____)
Do you have a job? ☐ Yes ☐ No
What work do you do? How many hours per week do you work?
_____

FORM COMPLETED BY: _____