Name:       Date:

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| --- |
| Address:       Phone number:      DOB:       Age:       Physician:        |

Nutrition Assessment:

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| Most recent Total cholesterol:       |
|  LDL-cholesterol:       |
|  HDL-cholesterol:       |
|  Triglycerides:       |
|  A1c       |
|  Blood sugar       |
|  Blood pressure:       |
| Ht:       Wt:       Recent Change?      BMI:        |
| Medical Conditions (Please list all conditions)                                          |
| Number of meals eaten in restaurants per week is:Type is mostly: [ ]  fast food *[ ]  not* fast food |
| Food Allergies:      Gastrointestinal issues: Do you have a regular bowel movement?      Gastrointestinal issues may include diarrhea, constipation, acid reflux, irritable bowel syndrome (IBS)Please explain:       |
| How many alcoholic beverages do you consume per day?      How many do you consume per week?      How many do you consume per month?      Tobacco use:        |
| Do you exercise?       Type:      Minutes each time:       Number of times per week:      Do you have any limitations?        |
| Highest education level:       |
| Employment: [ ]  FT [ ]  PT [ ]  Retired [ ]  No work Type of work:      Work is: [ ]  physically active [ ]  not active |
| How ready are you to change your behaviors?:low=0 [ ]  moderate=5 [ ]  high=7 [ ]  very high=10 [ ] Things in your life that would make behavior change more difficult(Examples: lost my job, living situation has just changed):       |
| Do you have any physical, emotional, or financial safety concerns you wish to discuss?       |
| What do you want to get out of the conversation today?       |

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| Day 1  | Amount | Food Consumed |
| BREAKFASTTime:       |            |                                                    |
| SNACKTime:      |            |                                                    |
| LUNCHTime:       |            |                                                    |
| SNACKTime:       |       |                                                    |
| DINNERTime      |       |                                                    |
| SNACKTime:       |       |                                                    |

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| Day 2 | Amount | Food Consumed |
| BREAKFASTTime:       |       |                                                    |
| SNACKTime:       |       |                                                    |
| LUNCHTime:       |       |                                                    |
| SNACKTime:      |       |                                                    |
| DINNERTime:      |       |                                                    |
| SNACKTime:       |       |                                                    |

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| **Medication** | **Dose** | **Frequency** |
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Name:       Date:

Please record all medications, herbal and vitamin supplements.

Record the dose and how often you take them.