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 |
| BREAKFAST  Time: |  |  |
| SNACK  Time: |  |  |
| LUNCH  Time: |  |  |
| SNACK  Time: |  |  |
| DINNER  Time |  |  |
| SNACK  Time: |  |  |

|  |  |  |
| --- | --- | --- |
| Day 2 | Amount | Food Consumed |
| BREAKFAST  Time: |  |  |
| SNACK  Time: |  |  |
| LUNCH  Time: |  |  |
| SNACK  Time: |  |  |
| DINNER  Time: |  |  |
| SNACK  Time: |  |  |

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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.