Adult Nutrition Assessment Form

Name _____ Birth Date_____ Age_____
Address _____
Telephone numbers _____ E-mail _____
Primary Care Physician _____
Health Insurance _____
Referred by _____
Today's Date _____

What concerns do you have about your diet and your health?

How can I help you? What kind of information and support are you looking for?

What are you doing for physical activity?

How much quality sleep time do you have per day?

Do you experience constipation, diarrhea, loose stool, heart burn, gas, or bloating? Difficulty swallowing?

List foods that you are allergic or digestively sensitive to and your reaction:

Height _____ Current weight _____
What is your desirable weight range _____

List all medications, vitamin, mineral, and herbal supplements that you are taking:
_____ _____ _____
_____ _____ _____
_____ _____ _____

Describe your health history and approximate date of diagnosis:
_____ _____
_____ _____
_____ _____
List significant diseases in your family's health history:
_____ _____
_____ _____

How would you describe your appetite?

Are there any foods or textures you dislike?

Do you feel in control of your eating? Please describe:

Do you have a history of disordered eating? Please describe:

Describe any special diets you have followed in the past and how they affected you:

Do you enjoy cooking?

Who does the grocery shopping and where?

How often do you eat out and where?