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Nutritional Assessment

Name: _____ DOB: _____ Age: _____ Date: _____

Medical
Current medical diagnosis, if applicable: _____
Current medications: _____
Physician or medical provider: _____
Medical history: _____
Family medical history: _____

Physical Status
Height: _____
Weight: _____
Usual adult body weight: _____ (Highest _____ at age _____) (Lowest _____ at age _____)

Lifestyle
Exercise: Yes / No If yes, how often? _____ Type: _____
Other Physical Activity: _____
Tobacco (If yes, how many and how often):_____
Alcohol (If yes, how many and how often):_____

Diet
Vitamin and mineral supplements: _____
Weight loss, herbal or sports supplements: _____
Food allergies: _____
Food dislikes: _____

Describe your daily eating habits:

How often do you eat at restaurants or consume take-out or fast food?

Describe your typical eating environment (e.g. alone, with a spouse or roommate, in car, at desk):

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Dietary Intake

Food Groups	*# Servings per day*	*# of consumptions per week*
Breads, cereal, pasta, rice, other grains		
Fruits		
Vegetables		
Milk, cheese, yogurt		
Meat, poultry, fish, eggs		
Lentils, beans, tofu		
Peanut butter, nuts		
Fats such as margarine, mayonnaise, sour cream		
Oils		
Fried foods or salty snack foods such as chips		
Desserts		

Products	*# Servings per day*	*# of consumptions per week*
Sweet beverages such as soda or fruit drinks		
100% fruit juice		
Alcohol		
Water		
Caffeine beverages such as soda, coffee, tea, or energy drinks		
Sports products such as drinks or bars		
Artificial Sweeteners such as Sweet n Low, Splenda, or Equal		