Initial Assessment

Please answer all questions as honestly as you can. You may leave blank any questions you do not feel comfortable answering. Write “N/A” for any question that does not apply to you.

GENERAL INFORMATION

Patient Name:
(Last)___________________________(First)____________________________(Middle)_________

Date of Birth ________________ Age ______________

Primary Physician_________________

Home Address (Street)____(City)_______________

(State)_____________________________ (ZIP)_______________

Telephone (Work or Cell Phone please circle which one) ___________________________________

Email Address ____

Occupation (if retired, note previous occupation) ____

Employer____

Marital Status _______________ Who lives in your household? ______________________________

Circle the last year of school attended, and degree if appropriate:

1 2 3 4 5 6 7 8 9 10 11 12 College 1 2 3 4 Master’s Level Doctorate Other____

Insurance (Company)______________________________(Group # or Policy)__________________

Does Insurance reimburse for Medical Nutrition Therapy? _______n/a__________

Recommending MD/Surgeon/Therapist/Health Professional: _______________________________

MEDICAL HISTORY

Please indicate Past and/or Current conditions

Anemia
Asthma
Bronchitis
Diabetes (Type I or Type II)
Hearing Loss
High Blood Pressure
Hypoglycemia
Kidney Disease
Lung Disease
Osteoporosis
TMJ
Spinal Cord Injuries
Joint Problems knee/shoulder/back/hip

Allergies
Arthritis
Broken Bones
Back/Spinal Injury
Cancer
Gastrointestinal/Stomach Problems
Head Injury
Heart Attack
Hernia
High Cholesterol
Tumors
Thyroid Problems

List and describe any other medical condition relevant______________________________________

DIETARY HABITS AND WEIGHT HISTORY

Current Height ______________________________Current Weight: _________________________

Highest adult weight _____ Date_____

My lowest adult weight ______ Date_____

Goal/Desired weight ___________________ How often do you weigh yourself_______________

Food or Medication Allergies____

Do you take vitamins, minerals, or nutritional supplements__________________________________
If yes, which ones and how much____

How would you describe your current weight____

How satisfied are you with the way you look currently ______________________________________

How does your weight affect your daily activities (getting dressed, working, etc.)________________

Why do you want to change your weight at this time (weight gain or weight loss)
____

Do you ever use laxatives, diuretics or diet pills to control your weight?______________________

Are you concerned about weight gain____

When is the first time you can recall being concerned with your weight______________________

How much time do you spend thinking about food, your weight, or how your body looks________

Do you ever go on a food eating binge, where you eat more than a typical meal portion and/or feel you won't be able to stop eating____

Do you ever vomit after you eat______________________ If so, how often__________________

Do you count calories or fat grams ____

Do you restrict to a set number of calories per day_________________ If so, how many________

Do you understand how to read food labels____

Have you followed other diets, medical nutrition therapy plans or methods involving nutrition related behavior changes____

Do you eat with friends and/or family____

Do you ever feel guilty or ashamed when you eat____

Can you tell when you are physically satisfied with the amount of food you have eaten____________

Can you tell when your stomach is "full"____

Can you tell when your stomach is "stuffed"____

How do you decide what foods to eat____

How do you decide when to eat____

How do you decide how much to eat____

How do you decide when to stop eating____

Can you tell when you are physically hungry____

Do you know if you are eating or drinking for reasons other than hunger or thirst_______________

List your favorite foods ____

Are there any foods that you avoid or will not eat at all____________________________________

OTHER HISTORY

Do you ever have heartburn or feel bloated____

Do you have any dental problems, or problems swallowing or chewing________________________

Do you have trouble with brittle nails or hair that is falling out_______________________________

Have you ever missed a monthly period________________________ When/how long____________

If not, are your periods light or irregular____

List any current or past forms of exercise ____

____

Has anyone ever told you they were concerned about your eating habits

____

GOALS

Please write 3 goals for seeking out treatment for your concerns using medical nutrition therapy

1.

2.

3.

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