

Adult Nutrition Assessment Form

Please complete the questions below so that we may work together to achieve your nutrition, health and fitness goals. I respect the confidential nature of this information, and will not release it without your permission, or as required by law.

Name _____ Birth Date _____ Age _____

Address _____

Telephone numbers _____ E-mail _____

Primary Care Physician _____

Health Insurance _____

Referred by _____

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 do you enjoy doing for physical activity?

How much quality sleep time do you have per day?

Do you experience constipation, diarrhea, heart burn, gas, or bloating on a regular basis?
Please describe:

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

Height _____ Current weight _____

What is your desirable weight range _____

Please list all medications, vitamin, mineral, and herbal supplements that you are taking,
or attach a list:

_____	_____	_____
_____	_____	_____
_____	_____	_____

Please describe your health history and approximate date of diagnosis:

Please list significant diseases in your family's health history:

Diet History

Please describe your appetite? _____

What are your favorite foods? _____

What foods do you dislike? _____

Do you feel in control of your eating? _____

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

Please 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? _____

Please record what you are eating and drinking for 5 days; include time of day and estimated portion sizes:

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