Nutrition Solutions Adult Assessment

Name: _____ DOB: _____ Date: _____

Reason for Appointment: _____

For females only:

Do you have irregular periods: ☐ Yes ☐ No

If yes, please describe: _____

Are you pregnant: ☐ Yes ☐ No

How many times per day do you typically eat? _____

How many days per week do you skip: _____ Breakfast _____ Lunch _____ Dinner

Do you snack? ☐ Yes ☐ No When? _____

Describe your usual eating pattern (Check all that apply):

☐ Varies from day to day ☐ I eat more on the weekends ☐ Grazer

☐ I skip meals ☐ Nighttime eating ☐ 3 meals per day + snacks

☐ No pattern/random

	Not Confident				Very Confident
How confident are you in your ability to prepare/cook healthy meals?	1	2	3	4	5
How confident are you about being ready to make lifestyle changes?	1	2	3	4	5
How confident are you with your nutrition knowledge?	1	2	3	4	5
How confident are you about your ability to apply your nutrition knowledge?	1	2	3	4	5

Please list all vitamin, mineral, herb or other dietary supplements you are taking: _____

Are you currently taking a blood thinner called Coumadin or Warfarin? ☐ Yes ☐ No

Alcohol Intake: _____ Drinks per day _____ Drinks per week

Do you use other recreational drugs? ☐ Yes ☐ No

If yes, please list: _____

Patient Name:_____

DOB:_____

(or use patient label)

Name / MR # / Label

Do you have any dietary restrictions? ☐ Yes ☐ No

If yes, please list: _____

Do you have any food allergies or sensitivities? ☐ Yes ☐ No

If yes, please list: _____

Do you have any physical conditions that limit you from being active on a regular basis? _____

Do you engage in some type of regular movement or activity? ☐ Yes ☐ No

If yes, what do you do? _____

How often? _____ When you are active, about how long does it usually last? _____

Average hours of sleep in a 24 hour day: _____

Do you have problems with wakefulness or insomnia? ☐ Yes ☐ No

Have you attempted to change your weight in the last 5 years? ☐ Yes ☐ No If yes: ☐ Gain ☐ Lose

Please circle any weight management programs you have tried in the last 5 years.

Atkins	Keto	"Slimfast" or other Shakes
"Clean" eating	Nutrisystem	South Beach
Detox/Cleanses	Nutritionists	Weight loss (bariatric) surgery
Hospital Based Programs	Optifast	Weight Watchers
Jenny Craig	Paleo	Whole 30

Others, or on your own:

Have used any medication to help you change your weight in the last 5 years? ☐ Yes ☐ No ☐ Gain ☐ Lose

Meds: _____

What is your biggest health concern? _____

What would you like to achieve during your visit with the registered dietitian? _____

What other diet/health related information do you feel would be helpful for me to know? _____

Patient Name:_____

DOB:_____

(or use patient label)

Name / MR # / Label

Please check below if these statements describe your behaviors:

	Yes	No
I eat out more than 3 times per week.	☐	☐
I frequently eat sweets and desserts.	☐	☐
I drink less than 64 ounces of fluids per day.	☐	☐
I drink juice, punch, soda, sweet tea.	☐	☐
I drink coffee and carbonated beverages daily.	☐	☐
I eat more rapidly than other people.	☐	☐
I am an emotional eater or eat more when stressed.	☐	☐
I sometime feel out of control with the amount of food I am eating.	☐	☐
I eat more when I am alone.	☐	☐
I eat more at social events.	☐	☐
I eat when I am bored.	☐	☐
I have a relative or a friend who may not support my decision to lose weight.	☐	☐
I have problems with chewing and swallowing.	☐	☐
I have a difficult work schedule.	☐	☐
I may not be able to afford supplements.	☐	☐
I have not been able to remember to take vitamins and medications in the past.	☐	☐
I have difficulty making changes.	☐	☐
I have problems with my eyesight and/or hearing.	☐	☐
I have skipped meals because there wasn't enough money to buy food for myself and my family.	☐	☐
I experience frequent gastrointestinal symptoms (heartburn, nausea, abdominal pain, constipation, diarrhea, bloating, gas, etc.) that alter my food intake or decrease the quality of my life.	☐	☐

Over the past two weeks, have you experienced any of the following problems?

Little interest or pleasure in doing things.

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

Feeling down, depressed, or hopeless.

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

Have you ever been diagnosed with an eating disorder? ☐ Yes ☐ No

If yes, explain: _____

Patient Name:_____

DOB:_____

(or use patient label)

Name / MR # / Label

Please record foods, snacks, and beverages you eat over a 3 day period. This information will help us to provide the best recommendations for you.

Day 1

Time and Meal or Snack	Food or Beverage Item and Amount	Mood – Tired, Happy, Hungry, Stressed

Day 2

Time and Meal or Snack	Food or Beverage Item and Amount	Mood – Tired, Happy, Hungry, Stressed

Day 3

Time and Meal or Snack	Food or Beverage Item and Amount	Mood – Tired, Happy, Hungry, Stressed

Patient's Signature _____ Date _____ Time _____

Signature of Authorized Person _____ Date _____ Time _____ Relationship to Patient _____

If limited English proficient or hearing impaired, offer interpreter at no additional cost:

☐ Interpreter Accepted _____ ☐ Interpreter Refused

(Name/Number of Person/Services Chosen/Used)

Nutrition Solutions Adult Assessment

805534 R 02/06/2018

Name / MR # / Label