Nutrition Assessment

Name:_____ Date:_____

Address:_____City:_____State:_____Zip:_____

Home Phone: _____Cell:_____ Email:_____
DOB:_____ Age: _____ Height:_____ Usual Body weight: _____/_____
Recent weight loss/gain: _____ Over what period of time? _____
Do you currently exercise? □ Yes □ No
If yes, what type of activity, duration and how often?_____
_____
Appetite: □ Good □ Fair □ Poor
Has this changed recently?_____
Food allergies/intolerances: _____
Please list the foods not tolerated and the symptoms associated with these reactions:
_____
_____
Do you have headaches or other aches and pains?_____
Do you often eat fast foods, fried foods or ready prepared foods? _____
Do you regularly consume caffeine or sugar, or need these to get through your day?_____
Do you tend to overeat? _____What type of foods? _____
Do you feel hungry most of the day, with frequent thoughts of eating? _____
Do you have high blood pressure or elevated blood cholesterol? _____
Do you suffer from congested sinuses or increased mucus in your nose or throat?_____
Do you often feel tired or experience fatigue? _____
Do you experience constipation, bloating, gas, diarrhea, or digestive problems? _____
_____
Do you have hay fever, skin rashes, or asthma?_____
Please list current health conditions: _____
_____
_____
Please list all medications, vitamin/mineral supplements, dietary aids and herbs.
_____
_____
_____
Have you ever been involved in a weight loss program? □ Yes □ No
What was your outcome? _____
What is/are your goal(s) that brought you here? _____
_____
_____
_____
Notes: (for Heather)_____
_____
_____
_____

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HMD Nutrition