Health Concepts Nutrition Therapy

Denise Barratt MS, RD, LDN

Nutrition Assessment

Full name:_____

Address:_____City_____

State_____zip:_____

phone_____(home)_____(Work)_____(cell)

pager:_____fax:_____e-mail:_____

Social Security number:_____HIC#:_____

Name of your primary care physician:_____

Date of last physical:_____

State your reasons for seeking medical nutrition therapy:_____

Primary insurance provider:_____

Insurance number:_____

Primary policy holder other than patient's name:_____

Address if different from above:_____

_____

Secondary insurance carrier:_____

Have you had Medical Nutrition Therapy before:_____yes_____no

If so when?_____Age:_____Date of birth:_____Gender:_____

Questions:

1. **Do you have any dietary preferences or restrictions that may limit your food choices? If yes what?_____**

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24 Hour Diet History-Write down what you eat for 24 hours and then answer the questions on the following page:

Date	Time	Amount (Cups)	Location	Hunger Scale/Emotions	Food Eaten: don't forget beverages, margarine, sauces and salad dressings

1. **On most days how many meals and snacks do you eat each day?**

2. **How many meals a week are prepared at home? Who does the preparation?**

3. **How many meals are eaten out each week (this includes commercial food service, restaurant, deli or fast food provider)?**

4. **Where do you eat out?**

5. **How many days a week do you eat breakfast?**

6. **How often do you eat a meal or snack less than 2 hours before bedtime?_____everyday_____most days**

_____some days----------Rarely_____never

7. **How do your rate your appetite or desire for food?**

8. **What problems do you have trying to eat healthy?**

9. **How often do you stop eating after you feel that you have eaten enough?**

10. **Binging is the loss of control by eating a large amount of food over a short period of time. Do you ever binge?_____**

If yes, how many times a week?_____

11. **How many 8 ounce cups of water or non-caffienated beverages such as juice do you have on most days (do not include tea, coffee, beer or alcoholic beverages)?**

12. **How many caffienated beverages do you drink each day? (please include coffee, espressos, lattes, or caffienated soft drinks)_____**

13. **Have you had alcohol over the last 6 months?_____**

14. **If yes, how many drinks of beer, wine, liquor do you have per week? (one drink is 3-5 ounce wine, 10 ounce wine cooler, 12 ounce beer, or 1.5 ounce liquor)_____**

15. How much milk do you drink a day?

16.What type of milk do you choose?

17. When you choose foods, how many times a week do you choose hamburgers, sausages, luncheon meat, marbeled beef, sour cream, cheese, eggs, butter, pastry, ice cream, full-fat dairy products, chocolate, fried foods and fast foods:

_____Choose these nearly all the time
_____Choose at least once a day
_____Choose 3-4 times a week
_____Choose less than once a week

18. When you choose foods, how many times a week do you choose lean meats, skinless poultry, fish, low fat dairy, products, fruit, desserts, vegetables, pasta and legumes (beans and peas):
_____Choose these nearly all the time
_____Choose at least once a day
_____Choose 3-4 times a week
_____Choose less than once a week

Please answer the following as not at all, occassionally, moderately, quite often, or majority of the time

19. How often do you add salt to foods?

20. How often do you eat foods such as soy sauce, pickles, canned meats, salted nuts, potato or corn chips?

21. How often do you choose whole wheat bread or pasta, high-fiber breakfast cereal or brown rice?

22. Please list vitamin pills such as Vitamin C, calcium or other nutrient supplements that you take_____

_____

23.Please select which of the following describes your current activity level on most days:

_____Very light, _____light, _____ moderately active, _____very active, _____vigorously active

22.How much do you spend in moderate (walking, easy cycling, swimming, active gardening and gym workouts) **or vigorous** (jogging, running, active sports, heavy labor) **physical activity a week?**

___I am not physically active on a regular basis
___I do moderate activity less than 30 minutes at least 1-3 days a week
___I do moderate activity for less than 30 minutes at least 4-7 days a week.
___I do moderate activities at least 30 minutes at least 1-3 times a week.
___I do moderate activities at least 30 minutes at least 4-7 days a week.
___I do vigorous activitites for 30 minutes or more at a time at least 3 days of the week.

24.Has a doctor ever told you to restrict or limit physical activity or exercise?

25. Do you smoke cigarettes every day?_____If so, how many do you have?

26.Do you use other tobacco products?

27.Have you had an extra stressful event over the last year?

28.Good nutrition habits consist of eating a variety of food groups and limiting excess fat, alcohol or calories.

What is the current intention at this time to adopt good nutrition habits?

_____I am not planning to adopt any new nutrition or dietary habits this year.

_____I am planning to start making improvements in my nutrition and dietary habits in the next six months.

_____I am planning to start making improvements in my nutrition and dietary habits in the next 30 days.

_____I have adopted good nutrition and dietary habits and maintained them for less than 6 months.

_____I have adopted good nutrition and dietary habits and maintained them for more than 6 months.

Medical History:

1. **What medical conditions do you and your immediate relatives have?**

2. **Do you have food allergies? If so, what are they?**

Height:_____Weight:_____waist circumference:_____

3. **How much weight have you gained over the last year?**
4. **How much weight have you lost over the last year?**
5. **Lab Values (please include if you have this information)**

Blood Glucose:

Hemoglobin A1C:

Blood pressure:

Cholesterol:

LDL cholesterol:

HDL cholesterol: