**Nutrition Assessment Form (Fill out & bring in for initial Dietitian visit.)**

Current Height: \_\_\_\_\_\_\_ Present Weight: \_\_\_\_\_\_\_ What is your preferred weight?

What is your motivation to lose weight (health related, mobility related, task related, etc)?

What was your highest adult weight & how old were you at that age?

What was your lowest adult weight & how old were you at that age?

With whom do you live? [ ] Spouse [ ] Family [ ] Friend [ ] Alone

What is your employment status? [ ] Full-Time [ ] Part-Time [ ] Retired [ ] Student [ ] Other \_\_\_\_\_\_\_\_\_\_\_

If you work, what is your occupation? How many hours do you work?

Have you had previous weight loss surgery? Yes/No If yes, what surgery & when?

List any past diets/weight loss plans:

What age do you feel weight became a concern for you & why?

Briefly describe your past struggles with weight & what you believe has contributed to weight gain or inability to lose weight:

Have you seen a dietitian before? Yes/No If yes: When? Where? Why?

Do you take any supplements or vitamins? If so, please list them. Food Allergies/ Intolerances/ Preferences (i.e. Peanut allergy, Vegan, Vegetarian, etc)

Do you have a history of an eating disorder? Yes/No Explain

**Readiness Assessment**

I want to lose weight because:

If I could change 3 things about my health & nutritional habits, they would be:

The biggest challenge(s) to reaching my nutrition/weight loss goals are:

**Please check (✓) everything below that describes your personal eating pattern and/or lifestyle behaviors:**

|  |  |
| --- | --- |
| I eat large portions, get seconds or overfill my plate. | I don’t take time to plan healthy meals. |
| I skip meals or go for longer than 5 hours between meals.  | I am tempted by family & friends to eat unhealthy foods.  |
| I dine out more than 3 times a week.  | I lack the knowledge to cook healthy meals. |
| I frequently eat fried foods, fast foods, & high fat foods.  | I never feel “full” or satisfied after eating. |
| I frequently eat sweets & desserts (i.e. cookies, candy, cakes).  | When dieting, I go to extremes. |
| I graze or snack on food all day long, especially when doing other things like reading, watching TV, or while on the computer. | I drink less than 64 oz. or 8 cups of fluid daily. |
| I eat too quickly. | I usually drink two or more alcoholic drinks daily.  |
| I am an emotional eater. (I eat when I’m stressed, bored, sad, angry, anxious, etc.) | My work schedule hinders my weight loss efforts. |
| I am so busy, I forget to eat or I skip meals.  | I would have a difficult time reducing or giving up:  |
| I am a “picky” eater. | Other:  |

Who buys groceries in your home?

Who prepares meals in your home?

How many times per day do you eat Fruit? Vegetables? Grains? Protein?

How much water or non-caffeinated beverages do you drink per day in oz?

How many times per day do you eat on average? Do you snack in between meals?

Do you engage in physical activity? Yes/No If so, what do you do?

How often do you exercise? How long do you exercise?

**Diet Recall for a “typical day”:**

Breakfast-

Lunch-

Dinner-

Snacks-

**Motivation level to make changes:** (1= not motivated at all & 10= very motivated)

**Goals:**

|  |  |  |
| --- | --- | --- |
| Increase water intake | Increase fruit & vegetable intake | Stop smoking |
| Increase overall fluid intake | Increase protein intake & eat protein with each meal | Start exercising  |
| Decrease sugary beverage intake | Choose more whole grains & whole foods | Attend support group meetings |
| Decrease or stop alcohol intake | Measure portions | Gather information about surgery |
| Stop soda intake | Plan meals & prepare more meals at home | Engage support system in lifestyle changes |