Initial Assessment

Please answer all questions as honestly as you can. You may leave blank any questions you do not feel comfortable answering. Write "N/A" for any question that does not apply to you.

GENERAL INFORMATION

Patient Name:
(Last)_____(First)_____(Middle)_____

Date of Birth _____ Age _____

Primary Physician_____

Home Address (Street)_____(City)_____

(State)_____ (ZIP)_____

Telephone (Work or Cell Phone please circle which one) _____

Email Address _____

Occupation (if retired, note previous occupation) _____

Employer_____

Marital Status _____ Who lives in your household? _____

Circle the last year of school attended, and degree if appropriate:

1 2 3 4 5 6 7 8 9 10 11 12 College 1 2 3 4 Master's Level Doctorate Other____

Insurance (Company)_____(Group # or Policy)_____

Does Insurance reimburse for Medical Nutrition Therapy? _____n/a_____

Recommending MD/Surgeon/Therapist/Health Professional: _____

MEDICAL HISTORY

Please indicate Past and/or Current conditions

Anemia
Asthma
Bronchitis
Diabetes (Type I or Type II)
Hearing Loss
High Blood Pressure
Hypoglycemia
Kidney Disease
Lung Disease
Osteoporosis
TMJ
Spinal Cord Injuries
Joint Problems knee/shoulder/back/hip

Allergies
Arthritis
Broken Bones
Back/Spinal Injury
Cancer
Gastrointestinal/Stomach Problems
Head Injury
Heart Attack
Hernia
High Cholesterol
Tumors
Thyroid Problems

List and describe any other medical condition relevant_____

DIETARY HABITS AND WEIGHT HISTORY

Current Height _____Current Weight: _____

Highest adult weight _____ Date_____ My lowest adult weight _____ Date_____

Goal/Desired weight _____ How often do you weigh yourself_____

Food or Medication Allergies_____

Do you take vitamins, minerals, or nutritional supplements_____
If yes, which ones and how much_____

How would you describe your current weight_____

How satisfied are you with the way you look currently _____

How does your weight affect your daily activities (getting dressed, working, etc.)_____

Why do you want to change your weight at this time (weight gain or weight loss)
_____

Do you ever use laxatives, diuretics or diet pills to control your weight?_____

Are you concerned about weight gain_____

When is the first time you can recall being concerned with your weight_____

How much time do you spend thinking about food, your weight, or how your body looks_____

Do you ever go on a food eating binge, where you eat more than a typical meal portion and/or feel you won't be able to stop eating_____

Do you ever vomit after you eat_____ If so, how often_____

Do you count calories or fat grams _____

Do you restrict to a set number of calories per day_____ If so, how many_____

Do you understand how to read food labels_____

Have you followed other diets, medical nutrition therapy plans or methods involving nutrition related behavior changes_____

Do you eat with friends and/or family_____

Do you ever feel guilty or ashamed when you eat_____

Can you tell when you are physically satisfied with the amount of food you have eaten_____

Can you tell when your stomach is "full"_____

Can you tell when your stomach is "stuffed"_____

How do you decide what foods to eat_____

How do you decide when to eat_____

How do you decide how much to eat_____

How do you decide when to stop eating_____

Can you tell when you are physically hungry_____

Do you know if you are eating or drinking for reasons other than hunger or thirst_____

List your favorite foods _____
Are there any foods that you avoid or will not eat at all_____

OTHER HISTORY

Do you ever have heartburn or feel bloated_____

Do you have any dental problems, or problems swallowing or chewing_____

Do you have trouble with brittle nails or hair that is falling out_____

Have you ever missed a monthly period_____ When/how long_____

If not, are your periods light or irregular_____

List any current or past forms of exercise _____

_____

Has anyone ever told you they were concerned about your eating habits

_____

GOALS

Please write 3 goals for seeking out treatment for your concerns using medical nutrition therapy

1.

2.

3.

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Imagine wellness
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