NUTRITION THERAPY ASSESSMENT

Name: ____

Date of Birth: ___________________ Age/Gender: F/M________

Date: _________________ Diagnosis: ______________________

Profession: ____

Place of employment: ____________________________________

If student, school: _______________________________________

Year/Grade: ____

Living Situation: ____

Other Treatment Team Members:

Therapist:

Physician:

Psychiatrist:

Other experiences working with a Dietitian?

What is bothering you most about your eating/nutrition?

1.

2.

3.

Do others know about your struggles with your eating?

TIMELINE OF SIGNIFICANT EVENTS & TX HISTORY

HEALTH, EATING & WEIGHT HISTORY

Height: _____ ft. _____ in. Current Body Weight: _____ lbs.
Lowest weight: _____ lbs. When? ___/____ to ____/_____
Highest weight:______ lbs. When? ____/___ to ___/_____
How long have you been at your current weight? __________
Do you feel that you are at your ideal weight? Y / N
If not, what is your desired weight? __________________ lbs.
Do you weigh yourself? Y / N How Often? ___________

How does it affect your day?

"Set point" is a weight where the body tends to stabilize and eating patterns become easier to normalize.
What do you think your "set point" weight is? ____________

Last time you weighed this? ______ For how long? ________

Significant Health History?

Family Health History?

Medications/Nutritional/Herbal Supplements

Name	Dose

Past Diet Programs?

Do you commonly experience any of the following symptoms?

__ Fatigue
__ Dizziness
__ Frequent injury or illness
__ Cold sensitivity
__ Extreme hunger
__ Nausea
__ Lack of concentration
__ Lack of appetite
__ Weight fluctuations
__ Constipation
__ Diarrhea
__ Bloating

On average, how many hours do you sleep per night?

FOR FEMALES ONLY

Do you have regular menstrual periods? **Y / N**
Have you ever lost your period for three months or longer? **Y / N**
At what weight do your cycles become irregular or cease? ________
Do you take oral contraceptives? **Y / N** ____________________
Approximate date of last menstrual period? ___________________
What is your average weight fluctuation during your cycle?
____

EATING PATTERNS

Where do you get your nutrition information?

Food Allergies/Intolerances:

Food Fears:

Food Rituals:

Describe a "good" day:

Describe a "bad" day:

How many times per day (meals + snacks) do you eat? ___________

What meal is generally **a)** your largest meal? ___________________
b) the meal most frequently skipped? _________________________

Where do you eat most of your meals?
____
____

Foods most frequently eaten? 1. 2.

3. 4. 5.

Do you consciously limit or avoid any foods? Y / N
____
____

Are there foods you used to enjoy that you won't eat currently?

Describe intake of:
Water:
Soda:
Coffee:
Tea:
Diet Drinks:
Juice:
Gum/Candy:
Cigarettes:
Alcohol:
Sugar substitutes:

EATING PATTERNS

Does your food or weight feel out of control? Y / N
How much of your day is spent thinking about food & eating?
_____________________________________ %
Do you ever feel guilty after eating? Y / N

What do you do in this situation?

Do you feel you are getting enough to eat? Y / N

Do you know what hunger feels like? Y / N

Do you deny your hunger? Y / N

Do you know what satiety is? Y / N

Do you ever eat past the point of feeling comfortable? Y / N

Do you ever eat when you are not hungry? Y / N

Social Eating Patterns?

Which of the following describes your eating patterns?

- Eat 3 meals a day
- Eat a 'normal' amount of food
- Eat 3 meals with snacks
- Restrict intake of food
- Binge without purging
- Binge followed by vomiting
- Binge followed by restricting food intake
- Binge followed by laxatives
- Binge followed by diuretics or diet pills?
- Binge followed by exercise
- Vomit without binging
- Restrict food intake without binging
- Use laxatives without binging
- Use diuretics without binging
- Exercise excessively without binging
- Chewing and spitting food

Do you purge by:	Current	In the past
Vomiting		
Laxatives		
Enemas		
Diet/Water Pills		
Amphetamines		
Chew/Spit		

BODY IMAGE

How would you describe your body image?

Do you compare yourself to others?

Do you check your body?

How often? __________________ Any particular body parts?

Media that influences the way you feel about your body?

What do you like about your body?

EXERCISE & DAILY PHYSICAL ACTIVITY

What activities do you like to do?

Description of daily exercise?

Fidgeting?

If an athlete, specify sport: ___________________________________

Type of activity:	Frequency	Duration	Intensity

How do you feel if you can't exercise?

Describe past history with exercise:

Do you consider yourself a compulsive exerciser? Y / N

OVERVIEW

2. Recent changes to eating and/or exercise habits. When?

What do you hope to achieve as a result of nutrition counseling (long-term goals)

1.

2.

3.

Rate how important these changes are to you:
(0 not at all, 10 extremely)

0 1 2 3 4 5 6 7 8 9 10

Rate how confident you are to make these changes at this time:

0 1 2 3 4 5 6 7 8 9 10

What barriers, if any, stand in the way of you achieving your nutritional goals?

1.

2.

3.

ADDITIONAL PERTINENT INFORMATION

24-HOUR RECALL

Breakfast:

Lunch:

Dinner:

Snacks:

Fluids: