



Nutrition Assessment Questionnaire

Please bring this form completed to your first appointment

Name _____ Gender _____ Date _____

Address _____ City _____ Postal Code _____

Age: _____ Date of Birth _____

Home Phone _____ Work Phone: _____ Cell Phone _____

Email _____ Fax _____

Your Doctor's Name: _____ Phone Number: _____

Doctor's Address: _____ City: _____ Postal Code _____

Occupation: _____ Marital Status: _____

Children & Ages: _____

Do you have private insurance coverage for this service? Describe.

Do you need a detailed insurance receipt? _____

What specific condition(s) would you like this consultation to address?

Assessment of nutritional status ___

Improving eating habits ___

Decreasing body fat levels ___

Increasing lean body mass ___

Incorporating healthy meal & menu ideas ___

Assessing food sensitivities & intolerances ___

Motivation, support & encouragement ___

Other Concerns: _____

PERSONAL MEDICAL HISTORY

	√	List Details
Food allergies		
Food intolerance		
Constipation		
Vegetarian		
Eating Disorder		
Digestive issues		
Fatigue/sleepiness		
Frequent colds/flu		
High Cholesterol		
Osteoporosis		
Overweight/Obesity		
Heart Disease		
High Blood Pressure		
Diabetes		
Hypoglycemia		
Cancer		
Thyroid problems		
Low iron/anemia		
Depression/anxiety		
Frequent headaches/migraines		
Surgery		
Menopause		
Currently pregnant/breastfeeding		
Joint/back/tendon/muscular pain or injury		
Lung disease/asthma		
Other medical issues		

FAMILY HEALTH HISTORY

	√	List Family Member
Food allergies		
Osteoporosis		
Heart Disease/Disorder		
Overweight/Obesity		
High Blood Pressure		
Cancer		
Diabetes		
Arthritis		
Other medical issues		

OTHER PERSONAL INFORMATION

Current Weight _____ Current Height _____

Weight History (last 5 years) _____ Weight Goal _____

List all medicines, pills or drugs you are taking now, how many you are taking of each and how often do you take them?

List minerals, herbs and or vitamin supplements you are taking, how many and how often you are taking them? _____

How many hours a night do you sleep? _____

On a scale 1 to 5, what would your current "stress level" be 1 – Lowest
5 – Highest _____

Are you physically active now? Yes ___ No ___

List activity and frequency _____

How would you rate your present energy level?

Poor ___ Normal ___ High ___

EATING HABITS/ NUTRITIONAL HISTORY

Do you eat breakfast? Yes ___ No ___

Do you snack in the evening? Yes ___ No ___

Have you had any changes in your appetite lately? Yes ___ No ___

Do you have any sugar cravings? Yes ___ No ___

How many times a week do you eat out? _____

Check below the beverages you drink and indicate how much of each

Beverage	√	Number of cups or bottles per day
Water		
Coke		
Coffee		
Tea		
Fruit Juice		
Beer		
Milk		
Other		

Do you smoke or chew tobacco? Yes ___ No ___ If so for how many years?

Do you drink alcohol? _____

Do you overeat? Yes ___ No ___

Do you feel stuffed after your meals? Yes ___ No ___ Sometimes ___

How long does it take you to eat? _____

Do you have a peaceful environment when you eat? _____

Are you following any special diet or been on any diet? Yes _____ No _____

If so, what type of diet? _____

Do you have set meal times? Yes _____ No _____

Do you have any food restrictions, foods you dislike, or foods you choose not to eat?

Do you eat desserts, candy or other sweets regularly? Yes _____ No _____

Who does the grocery shopping in your house? _____

Who does the cooking in your house? _____

How much time do you have to devote to meal preparation and cooking?

Have you ever seen a registered dietitian, nutritionist or doctor of naturopathic medicine before? Yes _____ No _____

How do you feel a registered dietitian/nutritionist can assist you?

FOOD RECORD

On the following pages you will find a 3 day food and activity record. Record everything you eat in three days (preferably 2 days during the week, 1 day of weekend) and bring this to your appointment. Please try to be as specific and honest as possible so we can complete a detailed nutrition assessment of your intake.

FOOD RECORD DAY 1

Date _____

Did you eat: Less than usual the same as usual more than usual

Meal	Amount	Food eaten, cooking method, brand
Breakfast Time:		
Snack Time:		
Lunch Time:		
Snack Time:		
Supper Time:		
Snack Time:		

Physical Activity (Type and amount of time) _____

FOOD RECORD DAY 2

Date _____

Did you eat: Less than usual the same as usual more than usual

Meal	Amount	Food eaten, cooking method, brand
Breakfast Time:		
Snack Time:		
Lunch Time:		
Snack Time:		
Supper Time:		
Snack Time:		

Physical Activity (Type and amount of time) _____

FOOD RECORD DAY 3

Date _____

Did you eat: Less than usual the same as usual more than usual

Meal	Amount	Food eaten, cooking method, brand
Breakfast Time:		
Snack Time:		
Lunch Time:		
Snack Time:		
Supper Time:		
Snack Time:		

Physical Activity (Type and amount of time) _____
