# Initial Nutrition Assessment
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**NAME** ______________________________________ **DATE** __________________

**DOB:** _____/_____/_____ **AGE:** ______

**CURRENT WEIGHT:** _______________ **HEIGHT:** ______________

**LOWEST ADULT WEIGHT:** _______________ **HIGHEST ADULT WEIGHT**_______________

**MOST USUAL ADULT WEIGHT:** ____________________________

**DESIRED GOAL WEIGHT:** ____________________________________

**CHILDHOOD WEIGHT (circle one):** **UNDER** **AVERAGE** **OVER**

**CONTRIBUTING FACTORS TO OBESITY:**

______________________________________________________________________________

## Medical History

- ◻ **DIABETES**
- ◻ **HYPERTENSION**
- ◻ **SLEEP APNEA**
- ◻ **CANCER**
- ◻ **GI PROBLEMS**
- ◻ **CARDIOVASCULAR DISEASE**
- ◻ **ARTHRITIS**
- ◻ **HIGH CHOLESTEROL**
- ◻ **LIVER/RENAL DISEASE**
- ◻ **GALLBLADDER DISEASE**
- ◻ **GERD**
- ◻ **OTHER:** _____________________

**IS THERE FAMILY HISTORY OF OBESITY OR ANY OF THE ABOVE CONDITIONS? PLEASE SPECIFY:**

_________________________________________________________________________

**HISTORY OF ANOREXIA/BULIMIA/BINGE EATING?**

______________________________________________________________________________

**PLEASE LIST ANY FOOD ALLERGIES:**

______________________________________________________________________________

**DO YOU HAVE ANY DIET RESTRICTIONS?**

______________________________________________________________________________

**MEDICATIONS/SUPPLEMENTS:**

______________________________________________________________________________

**ARE YOU CURRENTLY EXERCISING? IF YES, WHAT IS YOUR REGIMEN?**

______________________________________________________________________________

**HOW MANY TIMES PER WEEK DO YOU EAT OUTSIDE THE HOME?** ___________________________

**HOW OFTEN DO YOU EAT THE FOLLOWING FOODS IN A WEEK?**
**○SWEETS (COOKIES, CANDY, ETC) __________ ○LIQUID SWEETS (SODA, JUICE, ETC) __________**
**○FRIED FOODS __________ ○SALTY SNACKS __________ ○FAST FOODS ____________________**

**WHICH OF THE FOLLOWING BEVERAGES DO YOU DRINK?**
**○ COFFEE ○ TEA ○ SODA ○ DIET SODA ○ WATER ○ JUICE ○ MILK ○ OTHER ________________**

**DO YOU CONSUME ALCOHOL? ___________________**
**IF YES, HOW OFTEN AND WHICH TYPE? ________________________________________________**

**DO YOU EAT FRUITS/VEGETABLES EVERYDAY? ________________________**
**IF YES, PLEASE SPECIFY TYPE & HOW MANY SERVINGS DAILY: _____________________________**

**DO YOU CONSUME DAIRY PRODUCTS DAILY? ____________________**
**IF YES, HOW OFTEN AND WHICH TYPE? ____________________________________**

**DO YOU EAT RED MEAT/CHICKEN/TURKEY/FISH/TOFU/BEANS/EGGS/NUTS? (circle answer(s))**
**DO YOU EAT AT LEAST 1 OF THESE DAILY? _________________**
**WHICH IS YOUR FAVORITE? _______________________________**

**DO YOU ADD BUTTER/MARGARINE/SALAD DRESSING/OIL/MAYONNAISE TO YOUR FOOD? If yes, please circle answer(s).**

**WHAT IS A TYPICAL BREAKFAST?**
______________________________________________________________________________

**WHAT IS A TYPICAL LUNCH?**
______________________________________________________________________________

**WHAT IS A TYPICAL DINNER?**
______________________________________________________________________________

**WHAT DO YOU LIKE TO SNACK ON?**
______________________________________________________________________________

**PAST METHODS/ATTEMPTS TO LOSE WEIGHT (i.e. WEIGHT WATCHERS, ATKINS, MEDICATIONS, EXERCISE, ETC):**

| TYPE | DATES | WEIGHT CHANGE |
|---|---|---|
| | | |
| | | |
| | | |
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