

Nutrition Assessment

Patient name: _____ Date of Birth ____ / ____ / ____

Please check all of the following statements, being careful to use the appropriate box related to the frequency of your personal habits.

Daily	3-5 per week	1-2 per week	1-2 per month	Less than monthly	Never	
						Cook meals at home
						Eat with others
						Eat at restaurants
						Eat at fast food restaurants
						Pastries, cookies, candies, ice cream, other sweets
						Add sugar to coffee, tea, cereals or other foods
						White bread or white flour products
						Colas or other soft drinks
						Artificial sweeteners (saccharin, Nutrasweet, Splenda...)
						Canned foods
						Cold breakfast cereals; list brands: _____
						Caffeine drinks (coffee, tea, cola, chocolate)
						Deep fried foods (chips, chicken nuggets, fish fillets, French fries)
						Margarine of any type
						Red meat (beef, pork, lamb)
						Processed meat (bologna, bacon, sausages, salami, etc.)
						Chicken or turkey
						Fish
						Shellfish
						Milk <input type="checkbox"/> Whole <input type="checkbox"/> 2% <input type="checkbox"/> 1% <input type="checkbox"/> Nonfat <input type="checkbox"/> Soy <input type="checkbox"/> Rice <input type="checkbox"/> Almond <input type="checkbox"/> Coconut <input type="checkbox"/> Flax <input type="checkbox"/> Other: _____
						Cheese
						Yogurt <input type="checkbox"/> Whole milk <input type="checkbox"/> Lowfat <input type="checkbox"/> Plain or flavored <input type="checkbox"/> Greek <input type="checkbox"/> Soy <input type="checkbox"/> Coconut <input type="checkbox"/> Other: _____
						Eggs
						Nuts and seeds (almonds, walnuts, cashews ...) <input type="checkbox"/> Raw <input type="checkbox"/> Roasted
						Whole grain hot cereals (oatmeal, Wheatena, etc.)
						Fruit <input type="checkbox"/> Raw <input type="checkbox"/> Frozen
						Vegetables <input type="checkbox"/> Raw <input type="checkbox"/> Cooked
						Green leafy vegetables <input type="checkbox"/> Raw <input type="checkbox"/> Cooked
						100% whole grains or whole grain breads
						Beans and legumes (lentil, kidney, chickpea, etc.)
						Herbs, fresh and dried, or spices
						Drink adequate water <input type="checkbox"/> Tap <input type="checkbox"/> Filtered <input type="checkbox"/> Bottled
						Alcohol
						Buy organic food and produce

Nutrition Assessment

Patient name: _____ Date of Birth ____/____/____

Dietary Intake

Do you have enough money to buy the food you need? Yes No

Do you have adequate kitchen facilities to store and prepare foods? Yes No

Are there foods you avoid? _____

Are there foods you crave? _____

Do you have any allergies or intolerances to food? _____

Do you have an Epi Pen for severe allergic reactions? Yes No N/A Expiration date: _____

Have you ever been diagnosed with an eating disorder? Yes No Unsure

Please describe: _____

Do you have concerns about your relationship with food? Yes No

If yes, please describe: _____

Check all that apply:

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Rushed at meals | <input type="checkbox"/> Sneak or hide food | <input type="checkbox"/> Eat at my desk | <input type="checkbox"/> Feel stuffed after meals |
| <input type="checkbox"/> Eat excessively if bored or emotional | <input type="checkbox"/> Feel out of control around food | <input type="checkbox"/> Eat in front of the TV | <input type="checkbox"/> Skip meals frequently |
| | <input type="checkbox"/> Get sick after eating | | <input type="checkbox"/> Feel satisfied after eating |

Dietary Diary and Instructions

Date: Write in the date of the diary entries. Record for 3-5 days.

Time: Write down, as accurately as possible, the time you eat.

Foods Eaten: Be sure to include fluids, vitamins, and medications, as well as foods.

Write in the amount of food you eat, like “1 cup of Cheerios with 4 ounces of milk and medium size banana.” Among the measurements you may use are fluid ounce, ounce-weight, cup, gram, teaspoon (jam, butter), slice (bread), tablespoon, gallon, liter, or milliliters.

If you list something as a “cup” (as in coffee or tea), a “glass” (milk, beer, water, etc.), or a “bottle” or “can,” estimate the size of the container (usually listed in fluid ounces). You may also write in just the quantity of the food when the amount is obvious, like “1 small hamburger with bun, 2 medium apples, 3 small cookies,” or a “serving of McDonald’s fries” (but write in whether it was a small or large order).

It is also important that you write in brand names of foods that you eat, as nutrient content will vary by manufacturer.

And finally, write in the contents of foods where appropriate. For example, instead of writing “vegetable soup,” write in “soup with carrots, vegetable broth, onion, garlic, etc.” for foods with multiple ingredients.

Feelings: Write in your emotions, as well as energy and physical stress levels. This is the place to chart your ups and downs during the day. Typical entries might include: “sad, depressed, high energy, low energy, very happy, tired, poor sleep last night, sleepy, runny nose, caught a cold, feeling very irritable, fighting with partner.” Do not limit yourself to just these entries. What is important is that you give us an idea of the ebbs and flows of your day. Try to correlate the entries as closely as possible with the times listed to the left on the diet diary form.

Bowel, Urine Habits, Gas: List your bowel movements, urine voids and any flatulence (gas). Again, try to correlate these entries with the times. Also, note any changes or abnormalities in bowel movements or urine, such as constipation, diarrhea, excessive quantity of urination, color changes, etc.

Major Activities: List your activity level (i.e., whether you are sedentary or active). Typical listings might include, “short walk, worked in the garden, ran three miles, sat in the office all day.”

Diet Diary

Name

Date	Time	Foods Eaten - Include also fluids, vitamins and medications	Feelings - Emotions, Physical Stress Levels	Bowel/Urine Habits Gas	Major Activities