Nutrition Assessment

Name:	**Date of Birth:**	**Phone:**
Today's Date:	**Select One:** Student Faculty Staff Private	**NetID:**
If you are a student, what is your classification: Freshman Sophomore Junior Senior Graduate Student		

Please select your sex:

Male	Female

Reason(s) for Nutrition Consult:

Food and Nutrition-Related Goals:

Do you have any of the following medical conditions?

	Diabetes
	High Blood Pressure
	High Cholesterol
	Kidney Disease
	Heart Disease
	Other

List any medications or vitamin/mineral supplements you take on a regular basis:

Weight History

Height: ________________ Current Weight: _______________

Have you had any recent changes in your weight that you are concerned about? ____ Yes ____No

If yes, please explain: ____

Please answer yes/no to the following questions:

Do you make yourself sick because you feel uncomfortably full? ____ **Yes** ____**No**
Do you worry you have lost control over how much you eat? ____ **Yes** ____**No**
Have you recently lost more than 15 pounds in a three-month period? ____ **Yes** ____**No**
Do you believe yourself to be fat when others say you are too thin? ____ **Yes** ____**No**
Would you say food dominates your life? ____ **Yes** ____**No**

For each statement, please tell me if it was often true, sometimes true, or never true:

Within the past 12 months I was worried about whether my food would run out before I got money to buy more.		
Often true	Sometimes true	Never true

Within the past 12 months the food I bought just didn't last and I didn't have the money to get more.		
Often true	Sometimes true	Never true

What food/nutrition concerns would you like to make sure the dietitian addresses during the visit: