

## Initial Nutrition & Health Assessment



Please complete this form prior to your Initial Consultation with our Registered Dietitian.

All answers remain strictly confidential.

### Demographics and History:

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Email: \_\_\_\_\_ Date of Birth/Age: \_\_\_\_\_

Occupation: \_\_\_\_\_ Height: \_\_\_\_\_

Current Weight: \_\_\_\_\_ Desired Weight: \_\_\_\_\_

Describe how your weight has trended over the years:

Smoker: \_\_\_\_\_ Pregnant: \_\_\_\_\_

Average hours of sleep per night: \_\_\_\_\_ Would you consider this quality sleep?

Do you suffer from longstanding constipation, frequent diarrhea or other gut/bowel sensitivities? If so, please explain.

\_\_\_\_\_

Current Supplements & Vitamins (NOT including prescription medication):

\_\_\_\_\_

Food Allergies or Intolerances:

\_\_\_\_\_

**Diet History:**

Who does the cooking in your home? \_\_\_\_\_

Who does the grocery shopping in your home? \_\_\_\_\_

Do you menu plan?

Have you ever seen anyone (R.D., ND, MD, etc.) about your diet? :

Previous diets:

What worked well on this (these) program (s)?

**Dietary Changes:**

What areas of your eating habits do you feel you are doing well with?

1.

2.

What areas of your eating habits do you feel you are struggling with?

1.

2.

What would you like the dietitian to help you with?

**Health Goals:**

What are your Top 3 Health Goals?

1.

2.

3.

**Current Physical Activity/Weekly Exercise Routine:**

Currently, I regularly complete deliberate exercise:

If yes, please describe: \_\_\_\_\_

\_\_\_\_\_

Yay! You are done! Thanks a lot.

Our Registered Dietitian will use this detail to customize your program. We can't wait to help you achieve all your health goals. See you at your appointment soon!