Appt. Date & Time: *Counselor:* _____
Appt. made by:

NUTRITION ASSESSMENT

Please bring all pertinent information to your appointment: medications, dietary supplements, and/or outside lab/blood work

A. Personal Data

Today's Date _____

Name _____ Preferred Name _____

e-mail _____ Birth Date _____

Phone Number _____ Okay to leave message? ❑ no ❑ yes

Age _____ Ht. _____ Wt. _____ Sex at birth: _____

Athletes

Sport: _____ **Position:** _____

Were you referred? ❑ no ❑ yes If yes, by whom? _____
Birth control? ❑ no ❑ yes Please list? _____
Do you have normal periods? ❑ no ❑ yes If not, how often? _____

Year in School:
1) Freshman
2) Sophomore
3) Junior
4) Senior
5) Grad Student

Race/Ethnicity (circle all that apply):
1) Caucasian/White
2) African American/Black
3) Hispanic
4) American Indian
5) Asian Am./Pacific Islander
6) Other: _____

Clubs or organization involvement on campus? *Please list all that apply:*

_____

1. Student status?
   1) Part-time undergraduate
   2) Full-time undergraduate
   3) Part-time graduate
   4) Full-time graduate
   5) None of the above

Major: _____ Units Completed: _____

2. Employment status?
   1) Work full-time
   2) Work part-time
   3) Unemployed
   4) Home-worker
   5) Other _____

How many hours a week do you work? _____

3. Which of the following best describes your current living situation?
   1) Live on campus in dormitory or apartment
   2) Live off campus by myself, with roommate(s), or significant other
   3) Live with parents or guardian
   4) Live in a fraternity or sorority house

B. Nutritional Status

Due to the short time frame please indicate what topics are priorities for the Dietitian or Nutrition Counselor to discuss. (Circle one)

1. Weight loss
2. Weight gain
3. Body composition
4. Meal planning
5. General nutrition info
6. Other (please specify) _____

Please answer the following:

Recent weight loss greater than 5 pounds within 30 days	☐ no	☐ yes
Are you currently on a weight reduction diet?	☐ no	☐ yes
Have you had a recent change in appetite?	☐ no	☐ yes
Do you have any problems with swallowing?	☐ no	☐ yes
Do you have any problems with chewing?	☐ no	☐ yes
Do you have any problems with sore mouth?	☐ no	☐ yes
Do you have any problems with nausea?	☐ no	☐ yes
Do you have any problems with diarrhea?	☐ no	☐ yes
Do you have any problems with vomiting?	☐ no	☐ yes
Do you have any problems with constipation?	☐ no	☐ yes

Other_____

Have you had a recent weight change within the last 6 months?

☐ no change ☐ increase ☐ decrease ☐ fluctuates ☐ do not know

Do you have an "ideal" or "goal" weight? ☐ no ☐ yes ☐ n/a

If yes, what is it?_____

Please elaborate: _____

Are you on ***any*** **medications*?** ☐ no ☐ yes ☐ n/a

If so, which one(s)? _____

_____

Who prescribed them for you? _____

Do you take ***any*** **dietary or herbal supplements*?** ☐ no ☐ yes ☐ n/a

If yes, which one(s)? _____

_____

Who prescribed them for you? _____

Please bring all medications and/or dietary supplements to your appointment!

C. Dietary History

1. Name some foods that you seldom/never eat and why *(religion, lifestyle, allergy, etc.):*

2. Who prepares your meals? _____
3. Where do you typically shop for food? _____
4. Are you on a special diet currently? ❑ no ❑ yes If yes, what kind? _____
   How long are/were you on the diet? _____
   Have you ever had a history of an eating disorder, purging, or binge eating?
5. Have you ever had a history of an eating disorder, purging, or binge eating? ❑ no ❑ yes
   If yes, when? _____
   Please explain: _____

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6. Do you currently suffer from disordered eating or an eating disorder? ❑ no ❑ yes
   Please explain: _____
7. Are you satisfied with your eating patterns? ❑ no ❑ yes
   If no, why? _____
8. Do you ever eat in secret? ❑ no ❑ yes
9. Does your weight affect the way you feel about yourself? ❑ no ❑ yes
10. Have any members of your family suffered from an eating disorder ❑ no ❑ yes
    If yes, whom? _____
11. On a scale from 1 to 10 (1 = no desire at all and 10 = strongly desire), please rate the following by circling a number:

- How important is it that you change your diet or behavior (lifestyle) to meet your goals?
  1 2 3 4 5 6 7 8 9 10
- How confident are you that you can make the desired changes to meet your goals?
  1 2 3 4 5 6 7 8 9 10

D. Medical History

1. When was the last time you saw a medical provider? _____
2. Do you have a history of medical issues? ❑ no ❑ yes If yes, please explain? _____
3. Have you had surgery before? ❑ no ❑ yes
   If yes, for what? _____

E. Athletic Participation & Activity

1. What is your training schedule? *Include practice times & general description of activities*:

   Monday: _____

   Tuesday: _____

   Wednesday: _____

   Thursday: _____

   Friday: _____

   Saturday: _____

   Sunday: _____

2. What types of exercise do you do **in addition to** practice/games?

_____

General Health

1. How much sleep do you get each night, on average? _____ hours

   Do you generally take naps during the day? ❑ no ❑ yes If yes, for how long? _____

2. Do you currently smoke cigarettes or chew tobacco? ❑ no ❑ yes

   How often and how much do you smoke? _____ Chew? _____

3. Do you consume alcoholic beverages? ❑ no ❑ yes

   If yes, how many beverages do you consume per day? _____

   Do you binge drink? ❑ no ❑ yes

   Definition: Men - ≥5 drinks; Women - ≥4 drinks in a 2 hour period

   Are you an occasional drinker (birthdays, holidays, etc.)? ❑ no ❑ yes

NOTE: Is there anything else you would like to discuss with the Dietitian or Nutrition Counselor?

_____

_____

_____

_____

Please write what you **eat <u>AND</u> drink** in a ***<u>TYPICAL</u>*** day in the space provided below.

**Please be as specific as possible. This will help us to better help you.*

Time	Food or Beverage	Amount	Location
Example			
9 am	*Orange juice*	*6 ounces*	*Home*
9 am	*Toast (Oroweat brand)*	*2 slices*	*Home*
9 am	*Peanut Butter (Skippy Crunchy)*	*1 tsp.*	*Home*