Hunterdon Health

Center for Nutrition & Diabetes Management

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Nutrition Self-Assessment

PLEASE USE PEN. DO NOT USE PENCIL.

Please fill out all of the information on this form and bring it to your nutrition appointment.

Name: ___________________________ **Date of Birth:** _______________ **Date:** ___________

Primary Care Physician: ____

The most important things I want to learn or discuss today:

1.____

2.____

Have you had previous nutrition education? ☐ Yes ☐ No

When? ___________________________ Where?_____________________________________

List your vitamins/supplements____

List any food and/or drug allergies ____

Exercise:

Do you exercise regularly? ☐ Yes ☐ No Type of exercise: _________ How often? _________

List any limitations with exercise: ____

____

Intake History:

Do you constantly feel concerned about eating or feel uncomfortable in social situations related to food? ☐ Yes ☐ No Please explain: ____

Do you drink alcohol? ☐ Yes ☐ No If so, how much? __________________________________

Who prepares your meals? ____

How many times a week do you eat away from home? ___________________________________

☐ Fast Food ☐ Restaurant ☐ Take Out ☐ Other____________________________________

Based on one day:

How much dairy do you consume? ______ How many vegetables? ______ Fruits? _______

What are your main beverages and how much? ____

Please list any trigger foods that make you overindulge: _______________________________

Please answer these statements below about your household in the last 12 months:

We worried that our food would run out before we got money to buy more.

☐ Often ☐ Sometimes ☐ Never

The food we bought just didn't last, and we didn't have money to get more.

☐ Often ☐ Sometimes ☐ Never

Please fill out the Food Diary on the next page.

Name:____ Date of Birth ________________

Height: ____________________________ Current Weight: ______________________________

Usual Body Weight: _________________ Goal Weight: ________________________________

Please record your food intake. What kind of food? How much food?

BREAKFAST Time_____	MORNING SNACK Time_____
LUNCH Time_____	AFTERNOON SNACK Time_____
DINNER Time_____	EVENING SNACK Time_____

____ RD Date:_____________

Notes/Comments:____

____

Daily Activities: ____

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