Nutrition Assessment Forms and Questionnaire

The following information will provide an assessment on the symptoms that you are currently experiencing. This information will allow us to adequate assess your situation and provide outstanding services.

Please complete it as accurately as possible!

This form will take some time to complete. Please have this form completed prior to your first session with the Registered Dietitian/Therapist.

Name: ____ Date: _______________________

Best Contact Phone Number: ___________________________ Email: ___________________________________

Agreement of Participation and Confidentiality

Your signature below indicates your permission and willingness to participate in the following assessment, future interviews, and to consider the potential programs available and recommendations provided. This may include, but not limited to dietitian/therapist interviewed, counseling, medical nutrition therapy, and subsequent dietary/nutrition/exercise/health recommendations. All information and data discussed, written, typed, or communicated will be held strictly confidential between the patient and ***Hope Restored Counseling of Florida, LLC*** professions.

Your signature indicates that the information provided by you in all requested forms, assessments, and counseling sessions is accurate and current to the best of your ability. ***Hope Restored Counseling of Florida, LLC*** commits to helping you reach your lifestyle goals; encouraging and motivating you to overcome obstacles; equipping you to make healthy lifestyle decisions and encouraging you to not five on yourself or your goals.

You also acknowledge that ***Hope Restored Counseling of Florida, LLC*** is not solely responsible for your complete healthcare and you will let us know of any changes or concerns in your health while you are receiving counseling with us.

Signature: ____

Please Print Full Name: __________________________________

We look forward to working with you on your journey to amazing health!

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Assessment:

What is the main purpose that you are requesting to see the Registered Dietitian (RD)? ________________________

____

____

What is your overall goal? ____

____

Section I. Demographic Information:

Gender: ☐ Female ☐ Male Date of Birth:__________ Age:_______ Ethnicity: _________________

Address: _________________________________ City: ______________________ Zip: ___________

Primary Care Physician (PCP): _______________________________

PCP's Address: ___________________________ City: _________________ State: _____ Zip: ______________

PCP's Phone Number: _______________________ PCP's Fax Number: ___________________________

Do you want your PCP to receive copies of your nutrition care plan? ☐ No ☐ Yes (A release will be needed)

Who referred you to ***Hope Restored Counseling of Florida, LLC***.? ____

Section II. Medical History:

Current Weight: ______ lbs Normal Weight: _____ lbs Weight 6 months ago: _____lbs Goal Weight: ______lbs

Are you experiencing any of the following? (check those that apply)

☐ Change in appetite
☐ Bleeding gums
☐ Bruising
☐ Chewing or swallowing
☐ Constipation
☐ Diarrhea
☐ Edema
☐ Indigestion
☐ Menstrual difficulties
☐ Sudden weight changes
☐ Stress
☐ Changes in vision

Do you currently smoke or use tobacco ☐ No ☐ Yes, what type ______ and how much __________

If no, did you ever smoke or use tobacco ☐ No ☐ Yes, when did you quit_______

Medical Conditions					
Please check "yes" for the health conditions that your doctor has diagnosed, and then record the approximate age/date at on-set					
Condition	**Yes**	**Age/Date at onset**	**Condition**	**Yes**	**Age/Date at onset**
Gastrointestinal			**Inflammatory / Autoimmune**		
Irritable Bowel Syndrome	☐		Chronic Fatigue Syndrome	☐	
Inflammatory Bowel Disease	☐		Rheumatoid Arthritis	☐	
Crohn's Disease	☐		Lupus SLE	☐	
Ulcerative Colitis	☐		Frequent Infections	☐	
Celiac Disease	☐		Severe Infectious Disease	☐	
Gastric or Peptic Ulcer Disease	☐		Herpes	☐	
GERD, reflux / heartburn	☐		Gout	☐	
Hepatitis C or Liver Disease	☐		Other: _______________________	☐	
Food Intolerance	☐				
Gastroparesis	☐				
Other:__________________________	☐				
Respiratory	☐		**Musculoskeletal/Pain**	☐	
Asthma	☐		Osteoarthritis	☐	
Chronic Sinusitis	☐		Chronic Pain	☐	
Sleep Apnea	☐		Fibromyalgia	☐	
Bronchitis or Emphysema	☐		Migraines	☐	
Tuberculosis	☐		Other: ________________________	☐	
Other: _________________________	☐				
Cardiovascular	☐		**Urinary / Reproductive**	☐	
Heart Disease/Heart Attack	☐		Kidney Stones	☐	
Stroke	☐		Urinary Tract Infections	☐	
Elevated Cholesterol	☐		Yeast Infection	☐	
Irregular Heart Rate	☐		Prostate Problem	☐	
High Blood Pressure	☐		Other:	☐	
Other: _______________________	☐				
Neurological / Brain	☐		**Metabolic / Endocrine**	☐	
Depression	☐		Type 1 Diabetes	☐	
Anxiety	☐		Type 2 Diabetes	☐	
Bipolar Disorder	☐		Metabolic Syndrome	☐	

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ADD/ADHD	☐		Hypoglycemia (low blood sugar)	☐	
Multiple Sclerosis	☐		Hypothyroidism	☐	
Seizures	☐		Hyperthyroidism	☐	
Anorexia Nervosa	☐		Polycystic Ovarian Syndrome (PCOS)	☐	
Bulimia	☐		Infertility	☐	
Binge Eating Disorder	☐		Other: ________________________	☐	
Any other Eating Disorder	☐				
Parkinson's Disease	☐				
Other: _________________________	☐				
Dermatological			**Cancer: List type(s) and treatment**		**Onset Date**
Eczema	☐				
Psoriasis	☐				
Acne	☐				
Other:_________________________	☐				

Additional health condition(s) your doctor has diagnosed:

Please list any previous injuries, surgeries, and hospitalizations. Provide age and date if known

Your birth Method: ☐ Vaginal ☐ C-Section | Were you breastfeed as an infant? ☐ Yes ☐ No ☐ Unknown

Family History

Have any of your immediate family (parent, siblings, grandparent, aunt/uncle) been diagnosed with the following? Please check, describe, and provide age at onset for all that apply.

Condition	**Yes**	**Family Member(s)**	**Age at on-set**	**Description**
Heart Disease	☐			
High Blood Pressure	☐			
Stroke	☐			
Diabetes	☐			
Cancer	☐			
Overweight/Obesity	☐			
Food Intolerance	☐			
Autoimmune Disease	☐			

Oral / Dental History				
Do you see a dentist at least twice a year for regular dental cleanings? ☐ Yes ☐ No				
How many times a day (on average) do you brush your teeth? ☐ Once ☐ Twice ☐ Three ☐ More than 3				

Allergies		Allergic Symptoms Experienced
Food		
Medication		
Supplement		
Environmental		

Medication and Supplements: Please list ALL prescription medications, nutritional supplements, and herbs/botanicals you are currently taking.
Any medications for Mental Health Disorders will be listed in that section.

Medication Name	Date Started	Dose	Frequency	Reason
Herb/Supplements	**Date Started**	**Dose**	**Frequency**	**Reason**

Have you had prolonged or regular use of NSAIDS (Advil, Alevel, Motrin, Aspirin, Etc._? ☐ Yes ☐ No

Have you had prolonged or regular use of Tylenol? ☐ Yes ☐ No

Have you had prolonged or regular use of acid-blocking drugs (Zantac, Pepcid, etc.)? ☐ Yes ☐ No

Have you taken antibiotics > 3 times per year? ☐ Yes ☐ No

Have you been on antibiotics long term (> 1 month continuously)? ☐ Yes ☐ No

Have you needed to have regular injections of a steroid medication (Prednisone or Medrol) for chronic pain?
☐ Yes , how often ____________________ ☐ No

Female Clients only: (*All others skip to Section III)*

Do you experience PMS (cramps, bloating, mood change, aches, and/or pains)? ☐ No ☐ Yes, ____________________

Do you have regular (every 23-28 day menstrual cycles? ☐ Yes ☐ No, describe ________________________________

Are your menstrual cycles: ☐ Normal ☐ Heavy ☐ Heavy with clots ☐ Light

How many days, on average, does your cycle last? ___________________________

Do you experience any strong food cravings before or during your cycle? ☐ No ☐ Yes, __________________________

Do you experience acne before or during your cycle? ☐ No ☐Yes

Do you experience menopausal symptoms? ☐ No ☐ Yes, what ____

Are you ☐ Perimenopausal ☐ Postmenopausal ☐ Neither, still menstruating

Are you currently using birth control/contraceptives? ☐ No ☐ Yes, how long _____________________

Are you currently on hormone replacement therapy? ☐ No ☐ Yes, how long ____________________

How many pregnancies? ___________ Miscarriages __________ Births ______________

Currently pregnant? ☐ No ☐ Yes, due _______________ Currently breastfeeding? ☐ No ☐ Yes

Are you trying to get pregnant? ☐ No ☐ Yes, how long _______

Any issues getting pregnant? ____

Section III: Mental Health History

Have you ever been diagnosed with a mental health disorder: ☐ No ☐ Yes

If yes, when _____________ and what was the diagnoses ____

Are you currently under the care of a psychiatrist _______ psychologist _______ mental health therapist ___________

Are you currently on any medications for a mental health diagnosis? ☐ No ☐ Yes

If yes, please list any and all medications:

Name/Description	Condition prescribed for:	Dose/Quantity:	Frequency:	Start date:
Example: Xanax	Anxiety	1 - 0.5mg	3 x / day	11/23/18

Section IV: Nutrition History

How would you rate your overall diet? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Have you been advised by your primary care physician (PCP) to follow a special diet? ☐ No ☐ Yes

If yes, what was their recommendation? ____

Are you currently following that dietary recommendation? ☐ No ☐ Yes

If no, what is keeping you from following that recommendation? ____

What changes in your health or dietary habits would **you** like to make? ____

____

What nutrition concerns do you currently have? ____

____

What, if any, "diet" programs have you participated in (Paleo, Weight Watchers, Atkins, etc.) ______________________

What has been the results of these diets? ____

Do you have any special dietary restrictions for any reason (health, cultural, religious, other)? ☐ No ☐ Yes

If yes, please describe? ____

Are you following any of the following:

☐ Low-Fat ☐ Gluten-Free ☐ No Dairy ☐ Low Carb ☐ Vegetarian ☐ Vegan

☐ No Wheat ☐ High Protein ☐ Low Sodium ☐ Diabetic ☐ Other, _______________

Have you ever been diagnosed with an Eating Disorder (Anorexia, Bulimia, Binge Eating, other)? ☐ No ☐ Yes,

If yes, What ______________ When ______________ Currently in treatment ______ With whom ___________________

What is your normal meal pattern? (check all that apply): ☐ Breakfast ☐ Mid-Morning Snack ☐ Lunch

☐ Mid-Afternoon Snack ☐ Dinner/Supper ☐ Evening Snack ☐ Mid-Night Snack

Indicate the usual time you eat: ______ Breakfast _______ Lunch _______ Dinner ___________________ Snacks

Do you frequently skip meals? ☐ No ☐ Yes, which meal(s) and how often ___________________________________

Where do you eat on a regular basis? Check all that apply

☐ Home ☐ Work/break room/café ☐ Food Carts/Trucks ☐ At desk ☐ Car/vehicle

☐ In my room ☐ Restaurants ☐ Other: _________________

How often do you eat fast food or a restaurant, both eat-in or take-out?

☐ Most meals (greater than 7 meals a week ☐ Frequently (4-7 meals/week) ☐ Occasionally (1-3 meals/week)

☐ Rarely (less than 1 meal most weeks) ☐ Infrequent (less than 1-2 meals/month)

What fast food and/or restaurants do you frequently eat at or get take-out from? _______________________________

____

What do you typically drink throughout the day? Check all that apply and the number of 8oz cups per day, on average

☐ Water ______ ☐ Regular soda ______ ☐ Diet Soda ______ ☐ Fruit Juice _______ ☐ Energy Drinks _______

☐ Caffeinated Coffee______ ☐ Decaf Coffee______ ☐ Sweet Tea ______ ☐ Unsweet Tea ______

☐ Green Tea ______ ☐ Herbal Tea ______ ☐ Sports Drinks ______ ☐ Diet Drinks/Aids ☐ Other, ___________

Do you use artificial sweeteners (Stevia, Splenda, etc): ☐ Yes ☐ No

Do you drink alcohol? ☐ No ☐ Yes, How often _____________________ How much________________________

What do you typically eat for breakfast? ____

____

What do you typically eat for lunch (mid-day meal)? ____

____

What do you typically eat for supper/dinner (evening meal)? ____

____

If you snack, what do you typically snack on ____

Describe your typically Eating Style: (check all that apply)

☐ Fast eater ☐ Love to eat ☐ Eat because I must ☐ Don't know how to cook

☐ Family members have different tastes ☐ Emotional eater (stress, bored, sad, etc) ☐ Live alone/don't want to cook for 1 person

☐ After dinner grazer ☐ Late night-grazer ☐ Erratic eating patterns

☐ Eat too much ☐ Eat too little ☐ Meal skipper/frequently skip

☐ Travel frequently ☐ Poor snack choices ☐ Grazer/snack throughout the day

☐ Do not plan meals/menus ☐ Negative relationship with food ☐ Three meals a day

☐ Rely on convenience foods ☐ Struggle with eating issues ☐ Feed the family then myself

☐ Love to cook ☐ Time Constraint ☐ Eat healthy but don't like my body

☐ Hate to cook ☐ Eat to be healthy ☐ Confused about food/nutrition

☐ Eat for athletic performance ☐ Eat fast food frequently ☐ Dislike "healthy" foods

Are there any foods that you crave regularly? ____

Are there any foods that you avoid? ____

Is there anything else that you think the Registered Dietitian/Therapist would need to know that was not already

been asked?____

____

____

Section V: Weight History

Would you like to be weight and/or measured for a body composition assessment? ☐ No ☐ Yes

Height: _________ Current weight: ______ lbs Desired weight: ______ lbs

Highest adult weight: _______lbs When? __________ Weight 1 year ago: _______ lbs

Do you have a history of losing weight then gaining the weight back? ☐ No ☐ Yes

How would you describe your weight growing up? ____

How would you describe your current weight? ☐ Underweight ☐ Overweight ☐ Just right

Have you recently had changes in your weight that you're concerned about? ☐ No ☐ Yes

If yes, please explain: ____

How often are you weighing yourself? ____________________ Where are you weighing? ____________________

Are you happy with your current weight? ☐ No ☐ Yes

Have you tried to lose weight in the past? ☐ No ☐ Yes

If yes, please explain what method(s) you have used to lose weight? ____

____

____

Are you currently following a "diet" program? (Weight Watchers, Adkins, Keto, etc.) ☐ No ☐ Yes

If yes, which program? _____________________________ how long have you been on it? ______________________

What results have you seen so far? ____

What assistance were you hoping to receive today and in the upcoming sessions regarding your weight? __________

____

Describe any recent changes toward a healthier lifestyle that you have made? ________________________________

____

Is there any additional information that you feel may be relevant to understanding your weight health? ___________

____

Section VI: Digestive Health History

Do you associate any digestive symptoms with eating certain foods? ☐ No ☐ Yes

If yes, please explain: ____

How often do you have a bowel movement? ________________________

If you take laxatives, what type/brand and how often? ____

Would you describe your stools as ☐ Normal ☐ Hard ☐ Soft ☐ Loose

Please indicate how often you experience the following symptoms: check all that apply

Heartburn ☐ Often ☐ Sometimes ☐ Rarely

Gas ☐ Often ☐ Sometimes ☐ Rarely

Bloating ☐ Often ☐ Sometimes ☐ Rarely

Stomach pain ☐ Often ☐ Sometimes ☐ Rarely

Nausea/Vomiting ☐ Often ☐ Sometimes ☐ Rarely

Diarrhea ☐ Often ☐ Sometimes ☐ Rarely

Constipation ☐ Often ☐ Sometimes ☐ Rarely

Section VII: Activity and Exercise History

Do you enjoy physical active? ☐ Yes ☐ No, please explain ____

Please describe any movement you get during a typical day: ____

____

Which of the following describes the amount of moderate or vigorous active you have maintained in the past -26 months? This only include purposeful movement you do in addition to your normal activities of daily living (ADLs) on most days:

☐ Less than 30 minutes ☐ 30 – 60 minutes ☐ More than 60 minutes

☐ More than 120 minutes ☐ More than 180 minutes ☐ Participate in elite or professional sports/training

Please indicate all types of activity and the duration, that you regularly participate in:

Activity	Type	Intensity (low-moderate-high)	Number of days per week	Duration (time)
Stretching / Yoga				
Cardio / Aerobics: (Walk, jog, bike, swim, elliptical, etc.)				
Strength Training: (weight lifting, pilates, etc)				
Recreational Sports:				
Elite Sports or training: (Marathon, triathlon, sports)				
Leisure: Lawn games, gardening, etc.)				
Other, Specify				

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Do you have any barriers to participating in regular activity/movement? ☐ No ☐ Yes

If yes, please explain ____

Do you currently have anyone assisting you or training you in your exercise regimen? ☐ No ☐ Yes

If yes, please explain who, where, and how often: ____

Section VIII: Socioeconomic Information:

Circle the last year of school you attended:

6, 7, 8	9, 10, 11, 12	1, 2, 3, 4		
Grade school	High school	College	Masters	PhD.

Did you attend a trade school? ☐ No ☐ Yes

If yes, did you complete the program ☐ No ☐ Yes ☐ Not application (N/A)

Are you currently employed? ☐ No ☐ Yes

If yes, occupation ______________________________ Are you: ☐ Part-Time ☐ Full-Time ☐ Other, _________

If employed, how would you describe your routine? Check all that apply

☐ Working inside of the home / telecommuting ☐ Working outside of the home

☐ Work a regular 8-hour shift ☐ Work 10-12 hours shifts ☐ Other, ___________________

☐ Day shift ☐ Work evening ☐ Work overnight ☐ Rotating shifts

☐ Sedentary ☐ Some movement ☐ Moderate movement ☐ Physically demanding work

If not currently employed, why: ☐ Retired ☐ Laid off ☐ Student ☐ Disabled ☐ Other, ________________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Engaged ☐ Other, ____________

Do you have children: ☐ No ☐ Yes

If yes, are they living at home? ☐ No ☐ Yes

Section IX: Lifestyle

Do you have access to a refrigerator? ☐ Yes ☐ No Stove? ☐ Yes ☐ No Microwave? ☐ Yes ☐ No

<u>If no</u> to any of the above, please explain: ____

Who typically buys food, groceries, and/or meals for the household? ____

How many meals per week do you eat that are cooked at home? Breakfast _______ Lunch ________ Dinner_______

Who typically prepares meals at home? ____

How many meals per week are not prepared at home? Breakfast _________ Lunch _______ Dinner _________

Do you have any problems purchasing foods that you need/want to buy? ☐ No ☐ Yes

If yes, please explain ____

Do you use alcohol? ☐ No ☐ Yes, How many drinks a night _________ What type: _________________________

Do you use drugs ☐ Never ☐ In the past ☐ Currently ☐ Prefer not to discuss

If currently using, What type:_______________________________ Frequency: __________________________

How many hours a night, on average, do you sleep? ______ Weekdays _______ Weeknights

Describe your daily social media habits? ☐ Rarely on ☐ Occasionally on ☐ Frequently on

Describe your daily use of the internet? ☐ Rarely on ☐ Occasionally on ☐ Frequently on

Section X: Stress

Rate your overall stress level:

No Stress 0 1 2 3 4 *Moderate* 6 7 8 9 10 *a lot of stress*

Indicate daily stressors and rate the level of stress from 1 (low) to 10 (extremely high):

Work: _____ Family: ______ Social: _____ Financial:_____ Health: ______ Other, specify __________ rate_____

How you do you when you are stressed? (tense neck, etc): ____

____

What helps you manage stress? ____

____

How often do you participate in whatever helps you manage stress?

☐ Daily ☐ 5-6 ☐ 3-4 ☐ 1-2 ☐ Rarely

What keeps you from participate in whatever helps you manage stress? __________________________________

____

Section XI: Goals

What specific information would you like from the Registered Dietitian? _________________________________

____

What are your overall goals related to your nutrition health? ____

____

____

What is the most challenging nutrition/eating habit that you are experiencing currently? ______________________

____

What nutrition/eating habits are you currently satisfied with at this time? ____________________________________

____

If you could change three (3) things about your health and/or nutritional habits, what would they be:

1) ____

2) ____

3) ____

What keeps you from making these changes? ____

____

On a scale of 1 (not ready) to 5 (very ready),
please indicate your readiness/willingness to do the following:

To improve your health, how ready are you to…..	1	2	3	4	5
Significantly modify your diet					
Keep a record of everything you eat and drink every meal					
Modify your lifestyle (ex: work demands, sleep habits, physical activity)					
Participate in relaxation techniques					
Engage in regular exercise/physical activity					
Address any underlying mental health challenges keeping you from making changes					
Meet with the Registered Dietitian regularly to assess your progress					

Please Provide any additional information you feel may be relevant to understanding your overall needs: __________

____

____

Who will be your support system in helping you make necessary lifestyle changes? _____________________________

____

Would you like them to attend future sessions with the Registered Dietitian/Therapist? ☐ Yes ☐ No

Thank you for your willingness to share this information.

We look forward to working with you on your journey to amazing health!

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