

Nutrition Assessment

Client Information

Name: _____

Date of Birth: _____ Height: _____ (feet) _____ (inches)

Current Body Weight: _____ Desired Body Weight: _____

Lowest Body Weight: _____ Highest Body Weight: _____

When was the last time you visited your physician? _____

How would you rate your overall health? Excellent Fair Poor

Have you ever been diagnosed with any of the following (circle all that apply):

Diabetes	High Blood Pressure	High Cholesterol	Polycystic Ovarian Syndrome
Depression	Anxiety	ADHD	Thyroid Disease
Obesity	Anemia	Sleep Apnea	Food Allergies/Intolerances

Have you ever been diagnosed with an eating disorder? Yes or No

If Yes, Please Explain: _____

At what age did you get your first period? _____ Do you get regular periods? Yes or No

When was your last menstrual period? _____

Do you take any medications? (including laxatives and diuretics) Yes or No

If Yes, please list all: _____

Do you take any Vitamins or Mineral supplements? Yes or No

If Yes, please list all: _____

Have you seen a registered dietician in the past? Yes or No

If yes, when and why? _____

What are 3 things about your eating habits that you would like to change?

1. _____

2. _____

3. _____
