Medical Nutrition Therapy Assessment
For Adolescents
Ages 13-17 years old

Please help us provide better care to you by answering all questions to the best of your ability. This information will help the dietitian develop your nutrition treatment plan.

If you were referred to this appointment, who referred you (doctor, therapist, etc.)?
____________________________________________________________________________

Do you see any specialty providers (allergist, gastroenterologist, etc.)? If so, please list what types:
_________________________________________________________________________

Please share how you are hoping to benefit from meeting today and/or any nutrition concerns that you have (including concerns about your eating habits):
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

Have you worked with a Registered Dietitian in the past? _____Yes _____No
If yes, was it helpful? Why or why not?
____________________________________________________________________________
____________________________________________________________________________

Do you have any concerns with your current weight, body image, or body shape?  
_____Yes _____No  If yes, what are your concerns?________________________________________

Are you on a special diet?  ___Yes   ____No  
If yes, what?_______________________________________________

Is anybody you live with or that is in your family on a special diet?  ___Yes  __No  
If yes, what?_______________________________________________

Weight Loss/Gain  
Do you currently weigh yourself?  ____Yes  ____No  If yes, how frequently? ______________

How tall are you?______________________________
How much do you weigh? ____________________
Describe your growth pattern as a child (underweight, overweight, normal development):
______________________________________________________________________________
______________________________________________________________________________

Do you have a weight that you want to be? _______lbs
Have you ever been at this weight previously?  ___Yes  ___No  If so, what was your age?_____

Any recent weight changes?  ____Yes  ____No
If yes, please describe:
______________________________________________________________________________
______________________________________________________________________________

**Health History**

Please check any health concerns, add in any additional pertinent information.

- **Lung or Breathing Problems:**
  - □ Asthma
  - □ Bronchitis
  - □ Other __________

- **Cardiovascular:**
  - □ High cholesterol
  - □ High blood pressure

- **Endocrine:**
  - □ Thyroid problems
  - □ Diabetes

- **Autoimmune:**
  - □ Celiac Disease
  - □ Lupus

- **Other:**
  - □ Anemia
  - □ Liver disease
  - □ Kidney disease
  - □ Substance abuse
  - □ Difficulty chewing
  - □ Difficulty swallowing
  - □ Fetal Alcohol Spectrum Disorder
  - □ For females, age of first menses: _______
  - □ Any missed cycles?

- **Gastrointestinal:**
  - □ Abdominal pain
  - □ Cramping
  - □ Gas
  - □ Bloating
  - □ Constipation
  - □ Diarrhea
  - □ Non-celiac gluten sensitivity
  - □ IBS
  - □ Crohn’s Disease
  - □ GERD

- **Neurological:**
  - □ Seizures
  - □ Numbness/tingling in hands or feet
  - □ Dizziness
  - □ Trouble concentrating

- **Skin:**
  - □ Dermatitis herpetiformis
  - □ Other: ________________

- **Mental Health Diagnosis:**
  - □ Autism Spectrum Disorder
  - □ ADHD/ADD
  - □ __________________________
  - □ __________________________

**Allergies/Intolerances**

What allergies, sensitivities, and intolerances (to drugs, food, latex, environmental) or adverse reactions have you experienced?

<table>
<thead>
<tr>
<th>Allergic or intolerant to:</th>
<th>Reaction time:</th>
<th>Type of reaction or problem:</th>
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<td>(eg-immediate, slow, etc.)</td>
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Do you drink cow’s milk and/or eat dairy products? ___Yes ___No

If no, why not? ____________________________________________________________

Have you previously been tested for any food allergies or sensitivities?  ____Yes  ____No

If yes, please explain:

___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________

**Sleeping Patterns**

What time do you usually wake up? __________________

What time do you usually go to bed?_______________

Average hours of sleep per night? _________________

Do you ever get hungry before you go to bed or in the middle of the night? ___Yes ___No

If yes, describe________________________________________________________________

Any comments or history regarding your sleeping patterns (ex: sleep studies, current medications or supplements, etc.):

___________________________________________________________________________
___________________________________________________________________________

**Exercise Patterns and Attitudes**

Are you involved in any sports? ___Yes ___No

If yes, what do you do? How often do you practice and for how long?____________________________________________________________
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________

Do you do any other types of activity or exercise?___________________________________________
How many hours a day do you spend watching television or playing video games? Is it more or less hours on the weekends? Please describe:

Have you ever been told to stop doing exercise or activity? ____Yes ____No
If yes, why?
____________________________________________________________________________________

**Medications and Supplements**
List all medications you are currently taking.
☐ I am not currently taking any medications

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<th>Medication</th>
<th>Reason for Use</th>
<th>Negative side effects experienced</th>
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List all supplements you are currently taking.
☐ I am not currently taking any supplements

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<tr>
<th>Supplement</th>
<th>Reason for use</th>
<th>Dose and times per day</th>
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**Eating Patterns**
Where do you attend school? ________________________________________________

What meals or snacks are provided at school? ________________________________________
______________________________________________________________________________
______________________________________________________________________________

Within your household, who does most of the cooking? ________________________________
Within your household, who does most of the grocery shopping? ________________________
Do you eat family meals? ____Yes ____No
Please describe meal time: Who portions the food?
Are you a picky eater? ___Yes ___No
If yes, please describe: __________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Any feeding issues currently or as a child? ___Yes ___No
If yes, please describe: __________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Any texture issues with food? ___Yes ___No
If yes, please describe: __________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

How many times per week do you eat at restaurants or get take out? _______
Where do you go? What do you like to order?
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Do you have a concern with any of the following (check all that apply)?
☐ Binge Eating ☐ Purging ☐ Restrictive eating ☐ Overeating
☐ Night Eating ☐ Body Image ☐ Excessive exercise ☐ Other___________

Do you drink soda, coffee, or energy drinks? ___Yes ___No
If yes, what kinds and how much? _______________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Diet Recall: As best as you can recall, please write down your food and beverage intake from yesterday
(include meals, snacks, beverages, portions, and times)
Would you consider this a typical day? ___Yes ___No If no, why not?
_____________________________________________________________________________________
_____________________________________________________________________________________

**Motivation**

On a scale of 1-10, (10=extremely motivated; 1= no motivation at all), how would you rate your current motivation to make nutrition and lifestyle changes?
_____________________________________________________________________________________

What might make it hard to make changes?
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

Who are the support people in your life?
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________