Medical Nutrition Therapy Assessment
Adult: Ages 18+

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 describe what you want to achieve with today’s consultation:
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________

What specific nutrition goals are you hoping to work towards?
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________

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 shape, or body image? ____Yes ____No If yes, what are your concerns?
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________

Do you have any concerns with your eating habits? ____Yes ____No If yes, what are your concerns?
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
**Weight Loss/Gain**

Do you currently weigh yourself?  ____Yes  ____No  If yes, how frequently?  ______________

Current weight: _______#  Current height: _______

What was your highest body weight in adulthood?  _______lbs  What was your age? _______
What was your lowest body weight in adulthood?  _______lbs  What was your age? _______

Do you have a desired realistic body weight?  _______lbs

Have you ever been at this weight previously?  ____Yes  ____No  If so, what was your age? _______

Any recent weight fluctuations?  ____Yes  ____No
If so, please describe:
______________________________________________________________________________
______________________________________________________________________________

If you have ever attempted weight loss previously (including portion control, exercise, diet programs, books, pills, etc.), please write details below.

<table>
<thead>
<tr>
<th>Weight loss Method (name of pill, program, etc.)</th>
<th>Age</th>
<th>Brief Description</th>
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**Health History**

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

Lungs or Breathing:
- □ Asthma
- □ Bronchitis
- □ COPD

Cardiovascular:
- □ High cholesterol
- □ Heart disease
- □ High blood pressure

Gastrointestinal:
- □ Abdominal pain
- □ Cramping
- □ Gas
- □ Bloating
- □ Constipation
- □ Diarrhea
- □ Non-celiac gluten sensitivity
- □ IBS
- □ IBD
- □ GERD
- □ Diverticulitis
Bone Disease:
- Osteopenia
- Osteomalacia
- Osteoporosis

Endocrine:
- Thyroid problems
- Diabetes

Autoimmune:
- Celiac Disease
- Lupus
- Sjogren’s Syndrome
- Rheumatoid Arthritis

Other:
- Anemia
- Liver disease
- Kidney disease
- Substance abuse
- Weight gain (more than 10# in 1 year)
- Weight loss (more than 10# in 1 year)

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

Skin:
- Dermatitis herpetiformis
- Other:_______________

Mental Health Problems:
- _______________________
- _______________________
- _______________________
- _______________________

List all medications you are currently taking.
- I am not currently taking any medications

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<thead>
<tr>
<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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<thead>
<tr>
<th>Supplement</th>
<th>Reason for use</th>
<th>Dose and times per day</th>
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**Allergies/Intolerances**

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

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<th>Allergic or intolerant to:</th>
<th>Reaction time: (eg-immediate, slow, etc.)</th>
<th>Type of reaction or problem:</th>
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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 have cravings or urges to eat snacks in the middle of the night? ____Yes ____No
If yes, do you act on the urges? ____Yes ____No

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

**Exercise Patterns and Attitudes**

How frequently do you exercise?
☐ Daily  ☐ Weekly  ☐ Occasionally  ☐ Seldom/never

How long is your normal exercise period?
☐ 10-15 minutes  ☐ 20-40 minutes  ☐ 45-60 minutes  ☐ More than 60 minutes

What types of activity/exercise do you normally do?
_____________________________________________________________________________________
_____________________________________________________________________________________  
_____________________________________________________________________________________  
_____________________________________________________________________________________  
_____________________________________________________________________________________  

How confident are you that you can exercise regularly?
☐ Not at all confident  ☐ Slightly confident  ☐ Somewhat confident  ☐ Quite confident  ☐ Extremely confident
When you think about exercise, do you develop a positive or negative picture in your mind?

☐ Completely negative  ☐ Somewhat negative  ☐ Neutral  ☐ Somewhat positive  ☐ Completely positive

Is there any reason why you cannot or should not exercise?

____________________________________________________________________________________

**Eating Patterns**

Within your household, who does most of the cooking?

____________________________________________________________________________________

Within your household, who does most of the grocery shopping?

____________________________________________________________________________________

Where do you/they typically grocery shop?

____________________________________________________________________________________

How often is grocery shopping done?

____________________________________________________________________________________

On average, how much do you usually spend per month on groceries?

____________________________________________________________________________________

Are you currently receiving food support?  ____Yes  ____No  If yes, how much per month?

____________________________________________________________________________________

How many times per week do you eat at restaurants or get take out?

____________________________________________________________________________________

Please describe any details on locations, frequency, and foods ordered:

____________________________________________________________________________________

____________________________________________________________________________________

Please describe what hunger feels like to you:

____________________________________________________________________________________

____________________________________________________________________________________

Please describe what fullness feels like to you:

____________________________________________________________________________________

____________________________________________________________________________________

Do you ever eat in response to your emotions or out of boredom, even when not physically hungry?  ____Yes  ____No  If yes, what foods do you typically eat when you feel this way?

____________________________________________________________________________________

Do you have a concern with any of the following (check all that apply)?

☐ Bingeing  ☐ Purging  ☐ Restrictive eating  ☐ Compulsive eating

☐ Night eating  ☐ Social eating  ☐ Calorie counting  ☐ Other___________

Do you smoke?  ____Yes  ____No  If yes, how many packs per day?

____________________________________________________________________________________

Do you consume alcohol?  ____Yes  ____No  If yes, what amount and how frequently?

____________________________________________________________________________________

Diet Recall: To the best of your ability, 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 do you see as current barriers to making change?
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

What types of support are most beneficial for you?
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

Where/who do you currently receive support from?
_____________________________________________________________________________________
_____________________________________________________________________________________