Name:_____
Birth Date:_____ Today's Date:_____

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.

Weight loss Method (name of pill, program, etc.)	Age	Brief Description

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:

- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

Medications and Supplements

List all medications you are currently taking.

- ☐ I am not currently taking any medications

Medication	**Reason for Use**	**Negative side effects experienced**

List all supplements you are currently taking.

- ☐ I am not currently taking any supplements

Supplement	**Reason for use**	**Dose and times per day**

Allergies/Intolerances

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

Allergic or intolerant to:	Reaction time : (eg-immediate, slow, etc.)	Type of reaction or problem:

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 provide 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?

_____