# **Nutritional Assessment Form**

( Read the full article at: <https://nutriadmin.com/blog/nutritional-assessment-form> )

## **Personal Details**

|  |  |  |  |
| --- | --- | --- | --- |
| **First Name** |  | | |
| **Last Name** |  | | |
| **Date Of Birth** | Day | Month | Year |
|  |  |  |
| **Occupation** |  |  |  |
| **What is the activity level at your job?** | * **Sedentary** (mostly seated) | * **Moderate** (light activity  such as walking) | * **High** (very active, heavy labor) |
| **Height [cm]** |  |  |  |
| **Weight [Kg]** |  |  |  |
| **Gender** |  |  |  |
| **Age** |  |  |  |

## **Contact Details**

| **Email** |  |
| --- | --- |
| **Phone** |  |
| **Address** |  |
| **City/Town** |  |
| **Postcode** |  |

## **Consultation**

|  |
| --- |
| **Main symptoms/reason for this consultation** |
|  |

|  |
| --- |
| **Any additional concerns you would like to be addressed?** |
|  |

|  |
| --- |
| **What are your own lifestyle / wellbeing targets?** |
|  |

|  |
| --- |
| **What are your own dietary goals?** |
|  |

|  |
| --- |
| **What are your expectations of your practitioner?** |
|  |

## **Medical History**

| **Mark all prior/current diseases affecting you.** | | |
| --- | --- | --- |
| * **AIDS** * **Alcoholism** * **Allergies** * **Alzheimer's** * **Anemia** * **Arthritis** * **Asthma** * **Birth defects** * **Bleeding disorder** * **Cancer - breast** * **Cancer - colon** * **Cancer - prostate** * **Cancer - other** | * **COPD** * **Depression** * **Diabetes** * **Eating disorders** * **Emphysema** * **Epilepsy** * **Glaucoma** * **Heart attack** * **Heart trouble** * **High blood pressure** * **IBS** * **Kidney disease** | * **Liver disease** * **Mental illness** * **Migraine headaches** * **Pneumonia** * **Sickle cell anemia** * **Stroke** * **Suicide** * **Tuberculosis** * **Ulcers** * **Other** |

|  |  |
| --- | --- |
| **If you checked “Other”, please specify** |  |

## **Current Medications**

**Current Medications/Prescriptions**

*The purpose of this table is to inform of medication/prescriptions consumed by the patient CURRENTLY before the consultation*

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Product Name** | **Description** | **Purpose** | **Reason of Usage** | **Dose** | **Timing of Use** | **Using Since** |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |

**Current Supplementation**

*The purpose of this table is to inform of any herbs or supplements consumed by the patient CURRENTLY before the consultation*

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Product Name** | **Description** | **Purpose** | **Reason of Usage** | **Dose** | **Timing of Use** | **Using Since** |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |

|  |  |
| --- | --- |
| **Other Current Therapies** |  |

## **Past Medical History**

|  |
| --- |
| **Prior Diseases** *Please list all prior diseases including previous prescribed drugs* |
|  |

|  |
| --- |
| **Prior Injuries** *Please list all prior injuries including previous prescribed drugs* |
|  |

|  |
| --- |
| **Prior Hospitalisations** *Please list all prior hospitalisations including previous prescribed drugs* |
|  |

|  |
| --- |
| **Prior Hospitalisations** *Please list all prior hospitalisations including previous prescribed drugs* |
|  |

|  |
| --- |
| **Prior Surgeries** *Please list all prior surgeries including previous prescribed drugs* |
|  |

|  |
| --- |
| **Prior Treatments** *Please list all prior treatments including prescribed drugs* |
|  |

## **Allergies**

| **Food Allergies (Confirmed or Suspected)** | | |
| --- | --- | --- |
| * **Mango** * **Strawberries** * **Rice** * **Garlic** * **Oats** * **Meat** * **Milk** * **Peanut** | * **Fish** * **Shellfish** * **Soy** * **Tree nut** * **Wheat** * **Hot peppers** * **Gluten** * **Egg** | * **Sesame** * **Cocoa** * **Celery** * **Mustard** * **Other** |

|  |  |
| --- | --- |
| **If you checked “Other”, please specify** |  |

| **Environmental Allergies (Confirmed or Suspected)** | | |
| --- | --- | --- |
| * **Pollen** * **Cat** * **Dog** * **Insect Sting** * **Mold** * **Perfume** * **Cosmetics** | * **Latex** * **Water** * **House Dust Mite** * **Gold** * **Chromium** * **Cobalt** * **Formaldehyde** | * **Photographic Developers** * **Fungicide** |

|  |  |
| --- | --- |
| **If you checked “Other”, please specify** |  |

|  |
| --- |
| **Do you have any medicine allergies? (Confirmed or Suspected)** *Please list all medicines* |
|  |

|  |
| --- |
| **Do you find any food or drink difficult to digest?** *Please specify which* |
|  |

## **Lifestyle**

|  |  |  |
| --- | --- | --- |
| **Do you smoke cigarettes?** | * Yes | * No |

|  |  |
| --- | --- |
| **If yes, how long have you been smoking?** |  |

|  |  |
| --- | --- |
| **On average, how many cigarettes do you smoke per day?** |  |

|  |  |
| --- | --- |
| **If you quit smoking, how long have you stopped?** |  |

|  |  |  |
| --- | --- | --- |
| **Do you drink alcohol?** | * Yes | * No |

|  |  |
| --- | --- |
| **How often do you consume alcohol?** |  |

|  |  |
| --- | --- |
| **On average, how many drinks do you have in a typical week?** |  |

|  |  |  |
| --- | --- | --- |
| **Do you consume caffeinated beverages such as coffee, tea, or energy drinks?** | * Yes | * No |

|  |  |
| --- | --- |
| **What type of caffeinated beverages do you drink?** |  |

|  |  |
| --- | --- |
| **How many glasses do you typically consume in a day?** |  |

|  |  |  |
| --- | --- | --- |
| **Do you use recreational drugs?** | * Yes | * No |

|  |  |  |
| --- | --- | --- |
| **Do you exercise regularly?** | * Yes | * No |

|  |  |
| --- | --- |
| **If Yes, how often?** |  |

|  |  |
| --- | --- |
| **If Yes, duration/type of workout?** |  |

|  |  |  |
| --- | --- | --- |
| **Do you have difficulty falling asleep, staying asleep, or waking up too early?** | * Yes | * No |

|  |  |  |
| --- | --- | --- |
| **Do you wake up feeling refreshed and well-rested, or do you often feel tired and fatigued?** | * Yes | * No |

|  |  |
| --- | --- |
| **How many hours of sleep do you typically get per night?** |  |

|  |  |  |
| --- | --- | --- |
| **Bowel movement every day?** | * Yes | * No |

## **Women Only**

|  |  |  |
| --- | --- | --- |
| **Do you take any contraception medication?** |  | |
| **Are you pregnant?** | * Yes | * No |
| **How many weeks are you into pregnancy?** |  | |
| **When is your pregnancy due?** |  | |
| **Are you breastfeeding?** | * Yes | * No |

## **Dietary Information**

|  |  |  |  |
| --- | --- | --- | --- |
| **Food Avoided For Religious Reasons** | * Beef | * Pork | * Lamb |

|  |
| --- |
| **Other Foods Avoided For Religious Reasons** *Please specify other food avoided* |
|  |

| **Diets Followed In The Past** | | |
| --- | --- | --- |
| * **Vegan** * **Vegetarian** * **Pescatarian** * **Wheat Free** | * **Gluten Free** * **Celiac** * **Grain Free** * **Paleo** | * **Raw** * **Low Fodmap** * **Lactose Intolerant** |

|  |
| --- |
| **Other diets followed** *Please specify the diet name and when followed* |
|  |

|  |
| --- |
| **How much time are you willing to spend on food preparation?** |
| * **I can make 3 home cooked meals a day.** * **I can make 2 home cooked meals a day.** * **I can make 1 home cooked meal a day.** * **I usually / open to meal prep.** * **I don't have time to cook.** * **I can't cook.** |

### **3-Day Food Diary**

Over the next three days, carefully document all foods and beverages you consume.

Use the provided examples as a guide. Include food descriptions, portion sizes, and any cooking methods or added ingredients as necessary. Remember to record everything, including snacks, meals, and beverages, and provide as much detail as possible.  
  
***NOTE:*** *There would be no judgment whether you're "eating healthy" or not. Please answer HONESTLY.*

## **Day 1**

|  |  |
| --- | --- |
| **MEAL** | **FOOD CONSUMED** |
| **Breakfast *Example*** 2 slices white bread  1 Tbsp peanut butter  1 Tbsp strawberry jam, unsweetened  1 Glass Water |  |
| **Mid-Morning Snacks *Example***  1/2 bag Doritos  1 can Coca Cola |  |
| **Lunch *Example***  1 cup white rice  1 slice roasted chicken, breast part, without skin  1 glass water |  |
| **Mid-Afternoon Snacks *Example***  1 pc apple, peeled  ¼ cup peanuts, roasted |  |
| **Dinner *Example***  1 cheese burger with 1 pc tomato, and 2 pcs lettuce  1 pc fried chicken, leg part |  |
| **Bedtime Snack *Example***  1 Glass Low Fat Milk |  |

|  |  |  |
| --- | --- | --- |
| * **Is this your usual intake?** | * Yes | * No |

## **Day 2**

|  |  |
| --- | --- |
| **MEAL** | **FOOD CONSUMED** |
| **Breakfast *Example*** 2 Slices White Bread  1 Tbsp Peanut Butter  1 Tbsp Strawberry Jam  1 Glass Water |  |
| **Mid-Morning Snacks *Example***  1/2 bag Doritos  1 can Coca Cola |  |
| **Lunch *Example***  1 cup white rice  1 slice Roasted Chicken  1 Glass Water |  |
| **Mid-Afternoon Snacks *Example***  1 pc Apple |  |
| **Dinner *Example***  1 Cheese Burger  1 serving Caesar Salad |  |
| **Bedtime Snack *Example***  1 Glass Low Fat Milk |  |

|  |  |  |
| --- | --- | --- |
| **Is this your usual intake?** | * Yes | * No |

## 

## **Day 3**

|  |  |
| --- | --- |
| **MEAL** | **FOOD CONSUMED** |
| **Breakfast *Example*** 2 Slices White Bread  1 Tbsp Peanut Butter  1 Tbsp Strawberry Jam  1 Glass Water |  |
| **Mid-Morning Snacks *Example***  1/2 bag Doritos  1 can Coca Cola |  |
| **Lunch *Example***  1 cup white rice  1 slice Roasted Chicken  1 Glass Water |  |
| **Mid-Afternoon Snacks *Example***  1 pc Apple |  |
| **Dinner *Example***  1 Cheese Burger  1 serving Caesar Salad |  |
| **Bedtime Snack *Example***  1 Glass Low Fat Milk |  |

|  |  |  |
| --- | --- | --- |
| **Is this your usual intake?** | * Yes | * No |

## 