NutriAdmin

Nutritional Assessment Form

Personal Details

First Name

Last Name

Date Of Birth (DOB)

Day | Month | Year

Occupation

Please enter current and previous occupation

Height [cm]

Weight [Kg]

Gender

- male
- female
- other

Age

Contact Details

Email

Phone

Address

Please enter your address

City/Town

Enter your city or town

Postcode

Enter postcode

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

Do you urinate frequently?

- ( ) Yes
- ( ) No

Consultation

Main symptoms/reason for this consultation

Please list all symptoms/reasons. If possible, rank them in terms of importance to you

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

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 YOU USE IT	DOSE	TIMING OF USE	USING SINCE
e.g. Lyrica Oral	Anticonvulsant	for Nerve Pain	My doctor recommended it a year ago	Two 25mg capsules per day	at breakfast and dinner	last 18 months

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 YOU USE IT	DOSE	TIMING OF USE	USING SINCE
e.g. Now Foods Magnesium	Magnesium supplement	for balancing my diet	My doctor recommended it a year ago	Two capsules per day	at breakfast and dinner	last 18 months

Other Current Therapies

e.g. osteopathy, acupuncture, etc

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 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

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

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

Women Only

Do you take any contraception medication?

If yes, please explain which kind

Are you pregnant?

- ( ) Yes

- [ ] No

How many weeks are you into pregnancy?

When is your pregnancy due?

Day | Month | Year

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
- [ ] Coeliac
- [ ] 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.*

Example:

Breakfast
2 slices white bread
1 Tbsp peanut butter
1 Tbsp strawberry jam, unsweetened
1 Glass Water

Mid-Morning Snacks
1/2 bag Doritos
1 can Coca Cola

Lunch
1 cup white rice
1 slice roasted chicken, breast part, without skin
1 glass water

Mid-Afternoon Snacks
1 pc apple, peeled
¼ cup peanuts, roasted

Dinner
1 cheese burger with 1 pc tomato, and 2 pcs lettuce
1 pc fried chicken, leg part

Day 1

	FOODS CONSUMED
Breakfast	
Mid-Morning Snacks	

	FOODS CONSUMED
Lunch	
Mid-Afternoon Snacks	
Dinner	
Bedtime Snacks	

Is this your usual intake?

- ◯ Yes
- ◯ No

Day 2

	FOODS CONSUMED
Breakfast	
Mid-Morning Snacks	
Lunch	

	FOODS CONSUMED
Mid-Afternoon Snacks	
Dinner	
Bedtime Snacks	

Is this your usual intake?

- ( ) Yes
- ( ) No

Day 3

	FOODS CONSUMED
Breakfast	
Mid-Morning Snacks	
Lunch	
Mid-Afternoon Snacks	
Dinner	

	FOODS CONSUMED
Bedtime Snacks	

Is this your usual intake?

- ( ) Yes
- ( ) No