Horizon West Nutrition Services
Nutrition Assessment

Patient Name: Physician: Phone: Email:				Date: DD/ MM / YYYY		
Sex: M F				DOB: DD/ MM / YYYY		
Height:	Weight:	BMI:	IBW:	%IBW:	UBW:	%UBW:
Blood Pressure: Date Taken:						

Health History	
Diagnoses:	
Family History	
Cancer Y N	High Blood Pressure Y N
Diabetes Y N	Osteoporosis Y N
Heart disease Y N	Thyroid Disorder Y N
High Cholesterol Y N	Other
Other	Other

Surgical History	
Date:	Date:
Date:	Date:
Date:	Date:
Date:	Date:

Laboratory Values	**Date:**
Sodium	Hemoglobin
Potassium	Hematocrit
Phosphorous	
BUN	HDL LDL
Creatine	Cholesterol
Glucose HbA1C	Triglycerides
Calcium	Albumin
Iron	PreAlbumin

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Medications (Include Supplements)	Medications (Include Supplements)

Do you have complaints about any of the following:		
Appetite Y N	Constipation Y N	High/Low Glucose Y N
Bleeding Gums Y N	Diarrhea Y N	Seeing in Dim Light Y N
Missing Teeth Y N Partial U L Dentures U L	Chewing Difficulties Y N Swallowing Difficulties Y N	Indigestion Y N
Edema Y N	Bruising Y N	Stress Y N
Sudden Weight Change Y N	Other	Other

Do you consume caffeine? Y N If yes, about how much?
Do you use tobacco in any way? Y N If yes, about how much?
Did you recently stop smoking? Y N
Do you enjoy physical activity? Y N
What types of physical activity do you do? How often do you engage in physical activity?
Food allergies or intolerances:

Do you follow a special dietary plan, such as low cholesterol, kosher, or vegetarian? Y N Explain:
Have you ever followed a special diet? Y N Explain:
Are there certain foods that you do not eat?
Do you eat at regular times each day? Y N How often?
Identify any foods you particularly like.

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What change(s) would you like to make?	
Improve my eating habits ____	Improve my activity level ____
Learn to manage my weight ____	Improve cholesterol/triglyceride levels ____
Manage my carbohydrates ____	Improve my understanding of how to prepare meals ____
Other:	

Please add any additional information you feel may be relevant to understanding your nutritional health.
To tailor your counseling experience to your needs, it would be useful to know your expectations. Please check one of the following to indicate the amount of structure you believe meets your needs:
____ Just tell me exactly what to eat for all my meals and snacks. I want a detailed food plan.
____ I want a lot of structure but freedom to select foods. I want to use the exchange system.
____ I want some structure and freedom to select foods. I want to use a food group plan.
____ I don't want a diet. I just want to eat better. I will just set food goals each week.

Socioeconomic History
Last year of school attended: Other type of school:
Are you employed? Y N Occupation: Are you disabled? Y N Are you retired? Y N
How many people in your household? Ages:
Present marital status: Single Married Divorced Widowed Separated Engaged
Who prepares most of the meals in your home? Shopping?
How often do you eat out? Where?
Have you made any food changes in your life you feel good about? Y N Explain:
Who could support and encourage you to make these changes?

Education Interests		
What additional information would you like from your Dietitian?		
Supermarket Shopping Tour	Eating Out	Exercise
Weight Management	Portion Size	Alcohol Calories

Healthy Food Preparation	Eating Less Fat	Meal Planning
Fiber	Walking Program	Snack Foods
Food Labels	Diabetic Meal Planning	Other:

24-hour recall/Typical foods consumed:

Estimated Nutrition Needs (Dietitian to Calculate)	
BEE:	Protein %/g:
Activity Factor:	CHO %/g:
Injury Factor, if Applicable:	Fat %/g:
Total Estimated Energy Needs:	Fluid/mL

Goals:
1.

2.

3.