Date: ___/___/____

Goodness Nutrition Center

MEDICAL NUTRITION THERAPY INITIAL ASSESSMENT

PATIENT INFORMATION

Name:

Height:	Weight:	Age:	Sex: __ Male __ Female	Date of Birth:
Occupation:			Last Grade of School completed:	
Home Phone:			Cell Phone:	Work Phone:

E-mail Address:

Race: __American Indian/Alaska Nation __Asian/Pacific Islander/Oriental
__Black/ African American __Caucasian __ Hispanic/Latino
__Other:

Language Preference: __English __Spanish __Other:

How many people in your household? _____

__ Married __Single __ Divorced __ Widowed

LEARNING STYLE

How do you learn best?	__Listening	__Reading	__Observing	__Doing
Do you have any trouble with:	__Hearing	__Seeing	__Reading	__Speaking

If yes, please describe:

MEDICAL HISTORY

Check the tests/procedures that you have had done in the past 1-2 months:

Weight : _____ A1C: _____

__Urine test for protein __Dilated eye exam
__ Blood pressure __Cholesterol __Dental exam
__Flu shot __Pneumonia shot __Foot exam by health care professional

Do you have any of the following?

__Eye problems __Heart problems __Sleep Apnea __Thyroid disorders
__Kidney Problems __High blood pressure __Asthma/Bronchitis/COPD __Chronic pain
__Dental Problems __High cholesterol __Hepatitis __Acid Reflex/GERD
__Numbness/tingling __Stroke __HIV/AIDS __Depression/Anxiety
__Feelings in hands/feet __Poor circulation __Tuberculosis __Sexual problems
__Cancer __Diabetes __GI Disorders

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PATIENT INFORMATION (continued)

In the past 12 months, have you been a patient in an emergency room? __Yes __No

In the past 12 months, have you been admitted to a hospital? __Yes __ No

Use of tobacco: __None __ Cigarette __Pipe __Chewing __Quit When?

Do you drink alcohol? __Yes __No

How many drinks _____ per day/week/month?	If yes, what type of alcohol?

EXERCISE

Do you exercise? __Yes __No Describe Activity: __Easy __Moderate __Strenuous

What type of exercise: __Cardiovascular (walking, running, swimming)
__Strength Training (weights, push-ups, sit-ups)

How often do you exercise?	How long?

MEDICATIONS (if preferred, you may attach a list of your current medications to this form. Include over the counter, nutritional supplements and herbs) Use back of form if needed.

MEDICATION NAME	DOSE (mg, mcg, etc)	HOW OFTEN (daily, twice daily, etc)

Do you have allergies to any medications? __Yes __No __Don't know

If yes, list reaction

How many times in a week do you forget to take your medicine? __None __1-2 __3-4 __5 or more

NUTRITION

Who is responsible for meal planning, grocery shopping, cooking, etc. in your household?
__Myself __Spouse __Shared __Other

How many times per day do you eat? __One __Two __Three __Four or more

Please mark any dietary restrictions: __None __Salt __Fat __Fluid __Sugar
__Other:

Has your weight changed over the past year? ___Yes __No

If yes, please describe how:

Have you ever tried to change your weight? __Yes __No

If yes, please describe in what way and how successful you were:

How many meals per week do you eat away from home? __None __1-2 __3-4 ___5 or more

Do you have any food allergies? ___Yes ___No

If yes, list:

Name:_____ Food Journal week of :_____

DAY	BREAKFAST	LUNCH	DINNER
Sunday			
Monday			
Tuesday			
Wednesday			
Thursday			
Friday			
Saturday			

Notes:

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