DCMC
Nutrition Assessment

Please complete this nutrition assessment form and bring it to your first session. Completing this form prior to our appointment will save time during the session and allow us to maximize our time together. Please call with any questions! (214) 865-7004

Name:_____ Date of birth:_____

Phone number: _____(day) _____ (evening)

Email address:_____

Have you seen dietitian or nutritionist in the past? ◯ Yes ◯ No
If yes, was it helpful? Why or why not?

_____

_____

What do you hope to accomplish during your first consult?

_____

_____

Do you have any concerns with your current weight or shape? ◯ 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?

_____

_____

List all the diets you have tried including commercial diet programs, diets written about in books, and those that you have developed yourself and indicate your age at the time. Give a brief description of each diet.

Diet or program Age Brief description

_____

_____

_____

Are there any foods you avoid currently? ◯ Yes ◯ No If yes, please list below:

_____ For what reason? _____

_____ For what reason? _____

_____ For what reason? _____

_____ For what reason? _____

Do you have any food allergies or intolerances? ◯ Yes ◯ No
If yes, please list and explain:

_____

_____

How much alcohol do you drink in one week? _____

How many cups of caffeine-containing beverages do you drink daily? _____

Do you currently smoke? ◯ Yes ◯ No

If yes, how many cigarettes do you smoke per day?_____

If no, have you ever smoked? ◯ Yes ◯ No If yes, when did you quit?_____

Do you take any vitamin, nutritional, or herbal supplements? ◯ Yes ◯ No
If yes, please list each supplement and dose:

_____

_____

_____

Do you skip meals? ◯ Yes ◯ No If yes, which meals do you skip and how often?

_____

_____

Diet Recall: Please list everything you ate and drank from the time you woke up yesterday.
Time food/beverage and amounts:

Would you consider this a typical day? ◯ Yes ◯ No If no, why not?

_____

_____

Please provide an example of eating on weekend day if recall was a weekday, or please provide a weekday if recall was a weekend.
Time, food/beverage, and amounts:

What would you consider a "good day" of eating?
Time, food/beverage, and amounts:

What would you consider a "bad day" of eating?
Time, food/beverage, and amounts:

Within your household, who does most of the cooking? _____

Within your household, who does most of the grocery shopping? _____

Do you read nutrition labels? ◯ Yes ◯ No If yes, what do you look for?

_____

How many times per week do you eat at restaurants? _____

How many times per week do you eat at fast food restaurants?_____

Are you comfortable eating in restaurants? ◯ Yes ◯ No If no, why not?

_____

Do you count calories? ◯ Yes ◯ No If yes, why?

_____

Do you use diet pills? ◯ Yes ◯ No If yes, how often and what dose?

_____

Do you use laxatives? ◯ Yes ◯ No If yes, how often and what dose?

_____

Do you or have you ever made yourself vomit? ☐ Yes ◯ No If yes, how often?

_____

Do you binge eat? ◯ Yes ◯ No If yes, how often?

_____

Do you weigh yourself? ◯ Yes ◯ No If yes, how often?_____

Weight History

Height:_____

Current weight:_____

Weight 2 months ago:_____

Weight 6 months ago:_____

Weight 1 year ago:_____

Highest weight as an adult:_____ Age:_____

Lowest weight as an adult:_____Age:_____

Please explain any weight changes throughout your adult life.

_____

_____

Please describe your exercise routine and/or amount of physical activity (type, frequency, time).

_____

_____

Please circle how **confident** you are that you can change your eating behaviors.

NOT VERY CONFIDENT VERY CONFIDENT

1 2 3 4 5 6 7 8 9 10

Please circle how **motivated** your are to change your eating behaviors

NOT VERY MOTIVATED VERY MOTIVATED

1 2 3 4 5 6 7 8 9 10

Who is supportive of your efforts?

_____

Please provide any additional information that would be helpful for us to know.

_____

_____

If you have questions, please contact Huntington Thornton by phone at (214) 865-7004 during office hours or by email at Hthornton@dallascare.com anytime.