TAB 4

FORMS

Date:
Program:

CLIENT ASSESSMENT FORM

Name: ☐ M ☐ F	**DOB:**
Address:	
Email Address:	**Phone:**

ANTHROPOMETRICS:

Height: _____ **Weight:** _____ **Goal Weight:** _____ **Body fat %** _____ **RMR:** _____		
Medical History:	☐ Heart Disease	☐ Diabetes
	☐ High Chol/TG	☐ Cancer
	☐ HTN	☐ GI (IBS)/other

HEALTH & FITNESS GOALS:

1.

2.

3.

Previous weight loss experiences, successes, failures, programs, etc?

Year	Type	Why did it not work out?

How many times per week do you eat out?

Days	Restaurant	Breakfast/lunch/dinner?

What would you identify as your biggest obstacles to achieving your goals?

Medications/Supplementation:		
Type:	For:	Frequency Taken:
Food Allergies:		
Food:	Reaction You Had:	

HEALTH & FITNESS HABITS:

Exercise/week	☐ Sedentary (No exercise)				
	☐ 1-2 x/week	Type:		Duration:	
	☐ 3-4 x/week	Type:		Duration:	
	☐ 5-6x/week	Type:		Duration:	
Diet	Are you dieting?			☐ Yes	☐ No
	Number of meals you eat per day?				
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Soda	
	How much per day?				
Alcohol	Do you drink alcohol?			☐ Yes	☐ No
	If yes, how often?				
	How many drinks per week?				
Tobacco	Do you use tobacco?			☐ Yes	☐ No

SCHEDULE:

WEIGHT RECORD / PROGRESS NOTES:

	Date	Weight

DNEC
DIABETES & NUTRITION EDUCATION CENTER

DIABETES/NUTRITION ASSESSMENT FORM

NAME: _____ DATE: _____

HEALTH BELIEFS & ATTITUDES/ CULTURAL FACTORS *(Please explain any "Yes")*

Any concerns regarding your health? No / Yes: __Diabetes __Cholesterol __Weight __Blood Pressure __Kidney
OTHER:_____
Any financial concerns affecting diabetes care? No / Yes: _____
Any religious practices/restrictions affecting diabetes care? No / Yes: _____
Any other information:_____

MEDICAL HISTORY

You consider your health to be: [ ]Good [ ]Fair [ ]Poor
Do you take any medicines at home? No / Yes *(Please list dose and # times taken)* [ ] See attached list or MD's note

_____ _____ _____
_____ _____ _____
Do you take supplements: No / Yes: _____

Do you smoke? [ ]No [ ]Yes (# packs per day:____) Use alcohol? [ ]No [ ]Yes (# drinks per day____) or rarely

Health Care in past 12 Months	# of Visits	Reason
Primary Doctor		
Hospitalization / ER		
Eye Doctor		
Foot Doctor		
Diabetes Education / Dietitian		

EXERCISE ROUTINE: Do you exercise? No / Yes (If yes, you started, ____ days/months/years ago) # of minutes: ____/time
How often? _____ times per week Any physical limitations? Yes / No (If yes, explain: _____)
Type of exercise: ( )Walking ( )Bike ( )Physical Therapy ( )Gym ( )Other cardio_____

PERSONAL BEHAVIOR GOALS: (CAN BE RELATED TO DIET, BLOOD SUGAR MONITORING, EXERCISE, MEDICATION, ETC)

1-My long term weight goal is to ( )decrease _____lbs or ( )increase _____lbs, or ( ) maintain weight

2-Other personal health goals of mine are to:
( ) Make changes in my diet. To meet this goal I will _____
( ) Increase my Physical activity. To meet this goal I will _____
( ) _____

BARRIERS TO LEARNING & SOCIOECONOMIC STATUS

Do you have any of the following that may make it difficult for you to learn? [ ] Vision loss [ ] Reading problems
[ ] Hearing loss [ ] Emotional problems [ ] Language problems [ ] None [ ] _____

How do you learn best? (check one): [ ] Reading [ ] Listening [ ] Video [ ] Demonstration [ ] Any method

Primary Language: [ ]English [ ]Other _____

What do you do for a living? _____ Number of years of school completed: _____

SUPPORT SYSTEMS/ PSYCHOSOCIAL STATUS

[ ]Single [ ]Married [ ]Divorced [ ]Widowed Number people in household: ____ # Kids in household:_____

Primary emotional support person (circle one): self / spouse / parent / other _____
Any current major stresses? No / Yes (*If yes, explain*) _____

NUTRITIONAL SCREENING / CURRENT EATING HABITS Weight change in past 6 months? No / Yes: _____lbs (up / down)

Following any diet? No / Yes Diet History: Weight Watchers, Atkins, South Beach, Low Protein, _____

*****You vary what you eat. **Please mark/circle what you eat and drink on a *TYPICAL/USUAL DAY*:**

BREAKFAST *Time:*	**LUNCH** *Time:*	**DINNER** *Time:*	**SNACKS**
Skips? Yes # days/week:_____ Out / Home / both ( )Cereal ( )Oatmeal ( ) grits ( )pancakes/Waffles ( )Toast ( )Butter ( )Margarine ( ) Jelly ( )Eggs ( )Bacon ( )Sausage ( )Milk: skim / 1% / 2% /whole ( )Fruit ( )Yogurt ( )Fast Food: What you order? Drink:	Skips? Yes # days/week:_____ Out / Home / both ( )Sandwiches: cheese turkey ham tuna salami chicken hamburger ( )Mayo ( )Chips ( )Soup: Canned? ( )Leftovers ( )Frozen meals:Brand: ( )Full meal: ( )Chicken ( )Beef ( )Pork ( )Fish ( )Rice ( )Potato ( )Pasta/Noodle ( )Peas ( )Corn ( )Beans ( )Cooked Vegetables ( )Salad ( )Salads Dressing ( )Sour Cream ( )Fruit ( ) Cookies ( ) Dessert Drink:	Skips? Yes # days/week:_____ Out / Home / both ( )Chicken ( )Beef ( )Pork ( )Fish (Fried Baked Grilled Boiled) ( )Rice ( )Potato ( )Pasta/Noodle ( )Peas ( )Corn ( )Beans ( )Cooked Vegetables ( )Salad ( )Salads Dressing ( )Sour Cream ( )Gravy ( ) Butter ( )Margarine ( )FROZEN MEALS ( ) SANDWICHES ( )_____ ( )Dessert ( )Fruit ( )Wine/Beer Drink:	**Mid Morning Snack:** (circle) None PB/Cheese Crackers Cookies Chips Crackers Fruits Nuts Juice Soda Cheese _____ **Afternoon Snack:** (circle) None PB/Cheese Crackers Cookies Chips Crackers Fruits Nuts Juice Soda Cheese Ice Cream **Bed Time Snack**: (circle) None PB/Cheese Crackers Cookies Chips Crackers Fruits Nuts Juice Soda Cheese Ice cream

Do you consume: __Juice __Regular Soda __Sweet Tea __Nuts __Cookies __Ice Cream __Cheese __Candy __ Frozen Meals __ Canned Soup/Vegetables __ Chocolate __ Chips __ Fast Food __ Fries __ Fried foods

How often do you eat out? _____Times daily / weekly / monthly Who cooks? __ Self __ Spouse __ Other

Do you currently have problem with? Chewing: Yes / No Swallowing: Yes / No Lack of Appetite: Yes / No
3 or more Food Allergies: Yes / No Please explain any "Yes": _____

DIABETES ASSESSMENT: If you do NOT have diabetes skip this section. ( ) I have Pre-diabetes

How long have you has diabetes? _____ days / months / years What type: ( )Type 1 ( )Type 2 ( ) Don't know

What do you hope to learn about diabetes? [ ] diet [ ] blood sugar monitoring [ ] _____

Do you have any of the following problems (caused by diabetes)? *Circle ones that apply:*

Kidney Failure Heart Disease/Stroke Eye Problem Foot Problem Frequent Infections Sexual Problem Denial
Depression High Blood Pressure Gastroparesis Anger Stress Other: _____

Do you take diabetes medication?	Do you test your Blood sugar?	Do you have glucose over 200?	Do you have glucose below 70?	Do you test urine for ketones?
YES / NO	YES / NO	YES / NO	YES / NO	YES / NO
Which ones / How often	How often? Most recent fasting glucose: _____ 2hrs post meals: _____	If yes: ( )Daily ( )Rarely ( )_____	If yes: ( )Daily ( )Rarely ( )_____	

I certify that the above information supplied by me is true and complete to the best of my knowledge.
The above information will be reassessed with each patient follow up visit. Changes will be noted on "Follow up sheet".

_____ _____
Patient Signature Date

_____ _____
Clinician Signature Patricia M-Cali, MS, RD/LD, CDE Date

Food Preferences Questionnaire

This questionnaire asks about your food preferences and intake patterns. For each food item listed, please respond by indicating your preference for the food. If there are foods that you prefer that are not listed, please add them to the last page of this questionnaire.

Breads, Cereals and Grain Products

Description	Eat often	Eat sometimes	Rarely eat/do not like
Whole grain breads (whole wheat, rye, 7-grain, etc)			
White bread s(French, buns, rolls, etc)			
English Muffin, bagel, pita bread			
Flour tortillas (6-inch)			
Whole grain crackers (Wheat Thins, Triscuits, etc)			
Other crackers (Saltines, Ritz, etc)			
Corn Tortilla (6-inch)			
Muffins (berry, bran, corn, etc)			
Pancakes, waffles			
Oatmeal, regular			
Instant oatmeal, grits, cream of wheat			
Sugary cold cereals (frosted flakes, apple jacks, fruit loops, etc)			
Whole grain cold cereals (shredded wheat, Kashi, raisin bran, bran flakes, etc)			
Rice (brown or white)			
Pasta (whole wheat or white)			
Other whole grains (quinoa, millet, barley, etc)			

Fruits and Juices

Description	Eat often	Eat sometimes	Rarely eat/do not like
Apple or applesauce			
Banana			
Oranges, clementines or grapefruit			
Peach, nectarine			
Berries (Strawberries, Blueberries, raspberries)			
Cantaloupe			
Other melon (watermelon, honeydew)			
Pineapple			
Dried Fruits (raisins, dates, prunes, apricot, etc)			
Canned Fruit			
Orange or Grapefruit Juice			
Other juice (apple, grape, cranberry)			
Fruit Drinks (lemonade, punch, Koolaid)			
Tomato or Vegetable Juice			

Fats and Oils

Description	Eat often	Eat sometimes	Rarely eat/do not like
Vegetable Oils (corn, safflower, etc)			
Olive Oil			
Canola Oil			
Peanut Oil			
Shortening			
Margarine			
Butter			
Mayonnaise			
Creamy Salad Dressing (Ranch, Blue Cheese, etc)			
Vinaigrette Salad Dressing			
Light or reduced fat Salad dressing			

Milk, Yogurt, and Cheeses

Description	Eat often	Eat sometimes	Rarely eat/do not like
Whole Milk			
2% milk			
1% milk or nonfat (Skim) milk			
Chocolate milk			
Half and Half, cream			
Fruited yogurt (light or regular)			
Plain yogurt			
Hard Cheese: Cheddar, Colby, Monterey Jack, Swiss, etc.			
Soft Cheese: goat, feta, ricotta, brie, etc.			
Other Cheese: American, cream cheese, string, etc.			
Cottage Cheese			

Vegetables

Description	Eat often	Eat sometimes	Rarely eat/do not like
Lettuce: Romaine, mixed greens, iceberg, etc.			
Dark leafy greens: Spinach, kale, Swiss chard, etc.			
Carrots, raw or cooked			
Tomatoes (fresh or canned)			
Starchy vegetables: corn, peas			
Green beans, beets, zucchini, yellow squash			
Cauliflower, broccoli, Brussels sprouts, cabbage			
Asparagus			
Winter squash: Acorn, butternut, etc.			
White potato, baked, boiled or mashed			
Sweet potato or yams			
Avocado			
Olives			

Beverages

Description	Eat often	Eat sometimes	Rarely eat/do not like
Cola Drinks (Coke, Pepsi, etc.)			
Diet Cola Drinks			
Non-Cola Drinks (7-Up, Sprite, Slice, etc.)			
Diet non-Cola Drinks (7-Up, Sprite, Slice, etc.)			
Coffee or espresso			
Decaf coffee or espresso			
Tea			
Hot chocolate or cocoa			
Beer			
Wine			
Liquor: vodka, whiskey, gin, rum, etc.			
Mixed Drinks: Run & Coke, Margarita, Martini, etc.			

Protein Foods

Description	Eat often	Eat sometimes	Rarely eat/do not like
Legumes: Lentils, black beans, navy beans, chick peas, etc.			
Nuts and Seeds (peanuts, almonds, cashews, walnuts, sunflower seeds, etc.)			
Peanut butter, nut butters			
Tofu or other meat substitutes (Boca burger, Garden burger, etc.)			
Beef: steak, sirloin, pot roast, veal, etc.			
Beef: ground, cooked			
Pork: chops, roast, ham			
Lamb: chops, roast			
Poultry: chicken, turkey, duck			
Tuna fish (canned in water)			
Fresh/Frozen Fish: Salmon, tilapia, halibut, etc.			
Lunch meats: Turkey, ham, bologna, salami, etc.			
Eggs or Egg substitutes			
Hot Dogs or Sausage links			
Hummus dip			

Desserts and Sweets

Description	Eat often	Eat sometimes	Rarely eat/do not like
Cookies: chocolate chip, oatmeal, Girl Scout, etc.			
Doughnuts, scones, sweet muffins			
Cake, frosted			
Granola Bars (Nutrigrain, Quaker, Special K, etc.)			
Pie (Apple, Cherry, Pumpkin, Key Lime, etc.)			
Jell-O or other gelatin			
Pudding or custard			
Ice cream (scoop, bars, etc.)			
Sherbet or Sorbet			
Chocolate (Candy bars, chocolate bars, kisses, etc.)			
Hard candy (lifesavers, gum, jolly ranchers)			
Popsicles, frozen			
Sugar, honey, jam, jelly, syrups			

Miscellaneous

Description	Eat often	Eat sometimes	Rarely eat/do not like
Fast Food Pizza (Papa Johns, Dominoes, Pizza Hut, Tony's, etc.)			
Fast food Hamburger (McDonalds, Wendy's, Burger King, etc.)			
Fast Food Mexican (Taco Bell, Chipotle, Baja Fresh, etc.)			
Popcorn			
Potato Chips, corn chips, Tortilla chips			
Tomato based spaghetti sauce			
Cheese/cream based spaghetti sauce			
Sauces: Soy sauce, steak sauce, BBQ, etc.			
Soups: Vegetable or noodle type			
Soups: Creamy or potato			

Please add any foods below that are not indicated in the questionnaire.

Description	Eat often	Eat sometimes	Rarely eat/do not like

For each question, circle the response which best currently describes your usual behavior.

1.	How many days each week do you eat breakfast?	None	1-2 days	3-5 days	6-7 days
2.	How often do you eat between meals or after dinner?	Daily	1-2 days per week	Once a week or less	Seldom
3.	What is your usual pattern for the evening meal?	Biggest meal	Medium size meal	Light meal	Seldom eat dinner
4	Do the type of meals you usually eat include the following?	Red meats	Fish or chicken	Vegetarian meals	Vegan-no animal foods
5.	How much water do you drink each day?	Rarely	1-2 cups	3-5 cups	>5 cups
6.	Do you usually salt your food?	Freely	Moderately	Sparingly	Never
7.	Do you use non fat or reduced fat products?	Never	Rarely	Sometimes	Regularly
8.	What kind of spread do you use most often?	Butter	Stick margarine	Tub margarine	None of these
9.	Does your work or daily activity primarily involve the following?	Sitting	Standing	Walking or other activity	Heavy labor
10.	How often do you exercise for 20 minutes or more each week?	0-1 times	2-3 times	3-5 times	6 times or more
11.	Do you currently take a multivitamin?	Never	Rarely	Sometimes	Daily
12.	Do you take any other vitamin or mineral supplement?	Antioxidant	Calcium	Vitamin E	Vitamin C
13.	Do you take any other nutritional supplements?	Fish oil (EFA)	Probiotics	Protein Shake	Other

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One's health and well-being are influenced by many different things, including lifestyle, family history, emotional health, and nutrition/eating habits. Please complete the following questionnaire to the best of your ability to give us an overall view of your general lifestyle and health habits.

Nutrition Assessment Form

BASIC INFORMATION

First Name _____Middle Name_____Last Name_____

Birth Date _____/_____/_____ Age _____

Height: ___′ ____ ″ Weight: _____ Sex: _____

Occupation _____ Marital Status _____

Do you have children? Yes No Age of children_____

Are you pregnant? Yes No Due Date_____

With whom do you live? (Include children, parents, relatives, and/or friends. Please include ages.)
Example: Sarah, age 7, sister

_____

_____

_____

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Dietitian and Nutrition Educator
Email: lwagner@kumc.edu

GOALS AND READINESS ASSESSMENT

I would like to visit with the dietitian, today because…

_____
_____
_____

My food and nutrition-related goals are…

_____
_____
_____

My overall, health goals are…

_____
_____
_____

If I could change three things about my health and nutritional habits, they would be…

1. _____
   _____
2. _____
   _____
3. _____
   _____

The biggest challenge(s) to reaching my nutrition goals is/are:

_____
_____
_____

In the past, I have tried the following techniques, diets, behaviors, etc. to reach my nutrition goals…

_____
_____
_____

On a scale of 1 (not willing) to 5 (very willing), please indicate your readiness/willingness to do the following:

To improve your health, how ready/willing are you to…	1	2	3	4	5
Significantly modify your diet					
Take nutritional supplements each day					
Keep a record of everything you eat each day					
Modify your lifestyle (ex: work demands, sleep habits, physical activity)					
Practice relaxation techniques					
Engage in regular exercise/physical activity					
Have periodic lab tests to assess your progress					

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LIFESTYLE

Physical Activity: Using the table, please describe your physical activity.

Activity	Type/Intensity (low-moderate-high)	# Days per week	Duration (minutes)
Stretching/Yoga			
Cardio/Aerobics (walking, jogging, biking, etc.)			
Strength-training (weight lifting, pilates, some yoga)			
Sports or Leisure			
Other (specify/describe)			

Does anything limit you from being physically active?

_____

Indicate daily stressors and rate the level of stress from 1 (extremely low) to 10 (extremely high):

□Work_____ □Family_____□Social_____□Financial_____□Health_____ □Other_____

What helps you to unwind?_____

On average, how many hours of sleep do you get? Weekdays_____ Weekends_____

Do you smoke? ☐ Never ☐ In the past ☐ Currently How long?_____

Drug use ☐ Never ☐ In the past ☐ Currently ☐ Prefer to discuss with practitioner

Type/frequency_____

WEIGHT HISTORY:

Would you like to be weighed today? ☐ Yes ☐ No

Height _____ Current Weight _____ Desired Body Weight _____

Highest Adult Weight _____ When? _____ Weight 1 year ago _____

Have you had any recent changes in your weight that you are concerned about? ☐ Yes ☐ No

If yes, please explain:_____

_____

DIGESTIVE HISTORY

- Do you associate any digestive symptoms with eating certain foods? ☐ Yes ☐ No
- Please explain:_____
  __ _____
- How often do you have a bowel movement? _____

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- If you take laxatives, what type/brand and how often? _____
- Would you describe your stools are hard, soft, or loose? (circle one)
- Please indicate how often you experience the following symptoms:

Heartburn	Often	Sometimes	Rarely
Gas	Often	Sometimes	Rarely
Bloating	Often	Sometimes	Rarely
Stomach Pain	Often	Sometimes	Rarely
Nausea/Vomiting	Often	Sometimes	Rarely
Diarrhea	Often	Sometimes	Rarely
Constipation	Often	Sometimes	Rarely

DIET HISTORY

Do you follow any special diet or have diet restrictions or limitations for any reason (health, cultural, religious or other)? ☐Yes ☐No If so, please describe _____

Please list any food allergies, sensitivities or intolerances_____

_____

Who prepares the majority of your meals? _____ Who shops for food? _____

Where do you shop for food? _____

What percent of the foods you eat are… whole _____% organic_____% convenience _____%

If you do, how much time do you spend cooking/preparing meals each day?_____

Using numbers 1 (most often) through 6 (least often), please put in order the following cooking methods based on how often you use each cooking method:

Fry_____ Bake_____ Grill _____ Sautee _____ Steam _____ Microwave _____

Do you find cooking difficult? ☐Yes ☐No Please describe _____

INTAKE INFORMATION:

If you follow a special diet/nutritional program, check the following that apply:

☐Low Fat	☐Low Carb	☐High Protein	☐Low Sodium
☐No Gluten	☐Vegetarian	☐Vegan	☐Diabetic
☐No Dairy	☐No Wheat	☐Weight Loss	☐Other _____

Which meals do you eat regularly, check all that apply:

☐Breakfast ☐Lunch ☐Dinner/Supper ☐Snacks (time _____)

The nutrition/eating habits that are most challenging for me: _____

_____

_____

The nutrition/eating habits that I am most pleased with: _____

_____

_____

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Beverage Intake: Please indicate the beverages you drink, and how often you drink them. Fill in the "Daily Amount", "Weekly Amount", and/or "Monthly Amount"

Beverage Type	Daily Amount	Weekly Amount	Monthly Amount
Example: Coffee: X reg ☐decaf ☐latte	2 – 8 oz cups	—	—
Water: ☐tap ☐filtered ☐bottled			
Coffee:☐reg. ☐decaf. ☐latte			
Tea: what type(s)?_____			
Juice: ☐Natural ☐Fruit drinks			
Soda: ☐regular ☐diet			
Milk: ☐whole ☐2% ☐1% ☐skim			
Milk alternative Type_____			
Alcohol: ☐wine ☐beer ☐liquor			
Other _____			

Food Intake: Please indicate the frequency that you eat the following:

How often do you eat:	Never	2-3 times/mo.	1 time/week	2-3 times/week	2-3 times/day	1 time/day
Fast food						
Restaurant food						
Vending machine food						
Cafeteria or buffet food						
Frozen meals						
Home-cooked meals						
Leftovers						
Hamburger						
Steak						
Liver						
Ham						
Pork (chop/tenderloin)						
Bacon						
Lamb						
Chicken						
Turkey						
Deli meat, type:						
Fish, type:						
Soyfoods, type:						
Beans, type:						
Crackers, type:						
Cookies, cakes, muffins						
Whole grains, type:						
Fresh/Raw vegetables						
Cooked vegetables						
Fruit, fresh or frozen						
Fruit, canned (with syrup)						
Margarine						
Butter						
Cheese						
Yogurt, type:						

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How often do you eat:	Never	2-3 times/mo.	1 time/week	2-3 times/week	2-3 times/day	1 time/day
Olive oil						
Vegetable oil, type:						
Mayonnaise						
Salad dressing, type:						
French fries						
Potato and/or tortilla chips						
Fried chicken						
Fried fish						
Foods with added sweeteners/sugar, type:						
Foods with hydrogenated oils/trans-fats, type:						
Artificial sweeteners, type:						
Meal Replacements, type:						

Food cravings

_____

Food dislikes

_____

Eating Style: Based on how you eat on a regular basis, please check all that apply:

☐Fast Eater
☐Erratic eater
☐Emotional eater (stressed, bored, sad, etc.)
☐Late night-eater
☐Time constraints
☐Dislike "healthy" food
☐Travel frequently
☐Do not plan meals/menus
☐Rely on convenience items
☐Family member(s) have different tastes
☐Love to eat
☐Eat too much
☐Eat because I have to
☐Negative relationship with food
☐Struggle with eating issues
☐Confused about food/nutrition
☐Frequently eat fast food
☐Poor snack choices

The food/nutrition questions that I would like to ask are:_____

_____

_____

_____

_____

_____

_____

_____

THE NUTRITION CENTER @ CSU

Nutrition Assessment Form

Name: _____ DOB: _____ Age: _____ Date: _____

Medical

Reason for nutrition counseling: _____
Current diagnosis, if applicable: _____
Current medications: _____
Physician or medical provider: _____
Medical history: _____
Family medical history: _____
Pertinent laboratory values: _____

Physical Status

Height: _____
Weight: _____
Usual adult body weight: _____ (Highest _____ at age _____) (Lowest _____ at age _____)

FOR OFFICE USE
Measured Height: _____
Measured Weight: _____
BMI: _____
Waist circumference: _____

Lifestyle

Exercise: Yes / No If yes, how often? _____ Type: _____
Other Physical Activity: _____
Tobacco: _____
Alcohol: _____

Diet

Vitamin and mineral supplements: _____
Weight loss, herbal or sports supplements: _____
Food allergies: _____
Food dislikes: _____

Describe your daily eating habits:

How often do you eat at restaurants or consume take-out or fast food?

Describe your typical eating environment (e.g. alone, with a spouse or roommate, in car, at desk):

What is your primary goal for your nutrition counseling experience?

Dietary Intake

Food Groups	*# Servings per day*	*# Servings per week*
Breads, cereal, pasta, rice, other grains		
Fruits		
Vegetables		
Milk, cheese, yogurt		
Meat, poultry, fish, eggs		
Lentils, beans, tofu		
Peanut butter, nuts		
Fats such as margarine, mayonnaise, sour cream		
Oils		
Fried foods or salty snack foods such as chips		
Desserts		

Products	*# Servings per day*	*# Servings per week*
Sweet beverages such as soda or fruit drinks		
100% fruit juice		
Alcohol		
Water		
Caffeine beverages such as soda, coffee, tea, or energy drinks		
Sports products such as drinks or bars		
Chewing gum		

Behaviors Past or Present

Behavior	*Yes*	*No*	*Frequency*	*Most recent*
Count calories				
Count fat grams				
Dieting				
Diet pills				
Binge eating				
Fat restriction				
Fluid restriction				
Discomfort with your body size				
Other				

“Nestle Mini Nutritional Assessment MNA”

http://www.mna-elderly.com