

Appt. Date & Time:

Referred by:

Appt. made by:

NUTRITION INTAKE ASSESSMENT

A. Personal Data

Today's Date _____ e-mail _____

Name _____ Red ID _____

Phone Number _____ Birth Date _____

Age _____ Ht. _____ Wt. _____ Gender: Male / Female

Females: Are you on birth control? no yes If so, which one? _____

Do you have normal periods? no yes If not, how often? _____

Year in School:

- 1) Freshman
- 2) Sophomore
- 3) Junior
- 4) Senior
- 5) Grad Student

Race/Ethnicity (circle all that apply):

- 1) Caucasian/White
- 2) African American/Black
- 3) Hispanic
- 4) American Indian
- 5) Asian Am./Pacific Islander
- 6) Other: _____

Clubs or organization involvement on campus? -

1. What is your student status?

- | | |
|----------------------------|-----------------------|
| 1) Part-time undergraduate | 4) Full-time graduate |
| 2) Full-time undergraduate | 5) None of the above |
| 3) Part-time graduate | |

Major: _____ Units Completed: _____

2. What is your employment status?

- | | |
|-------------------|----------------|
| 1) Work full-time | 4) Home-worker |
| 2) Work part-time | 5) Other _____ |
| 3) Unemployed | |

How many hours a week do you work? _____

3. What is your marital status?

- | | |
|-------------|----------------------------------|
| 1) Married | 4) Separated |
| 2) Divorced | 5) Living with significant other |
| 3) Single | |

4. Which of the following best describes your current living situation?

- 1) Live on campus in dormitory or apartment
- 2) Live off campus by myself, with roommate(s), or significant other
- 3) Live with parents or guardian
- 4) Live in a fraternity or sorority house

B. Nutritional Status

Due to the short time frame please indicate what topics are priorities for the Dietitian or Nutrition Counselor to discuss. (Circle one)

1. Weight loss
2. Weight gain
3. Exercise
4. Lower fat/lower sodium diet
5. General nutrition info
6. Other (please specify) _____

Please answer the following:

- Recent weight loss greater than 5 pounds within 30 days no yes
- Are you currently on a weight reduction diet? no yes
- Have you had a recent change in appetite? no yes
- Do you have any problems with swallowing? no yes
- Do you have any problems with chewing? no yes
- Do you have any problems with sore mouth? no yes
- Do you have any problems with nausea? no yes
- Do you have any problems with diarrhea? no yes
- Do you have any problems with vomiting? no yes
- Do you have any problems with constipation? no yes
- Other _____

Have you had a recent weight change within the last 6 months?

- no change increase decrease fluctuates do not know

Do you have an "ideal" or "goal" weight? no yes n/a

If yes, what is it? _____

Are you on **any** medications? no yes n/a

If so, which one(s)? _____

Do you take **any** dietary or herbal supplements? no yes n/a

If yes, which one(s)? _____

C. Dietary History

1. Name some of your favorite foods. How often do you eat them?
2. Name some foods that you never eat and why they are not eaten (religion, lifestyle, etc.)
3. Name some foods that you seldom eat. Why?
4. Who prepares your meals?
5. Are you allergic to any foods? If so, what foods? no yes
6. Are you on a special diet currently? no yes
If yes, what kind? _____
How long are/were you on the diet? _____
How well did you stick to the diet? _____
7. Have you ever had a history of an eating disorder, purging or binge eating? *If yes, please explain:* no yes
8. Do you currently suffer from disordered eating or an eating disorder? no yes
9. Are you concerned with your body image? no yes
10. Are you satisfied with your eating patterns? no yes
11. Do you ever eat in secret? no yes
12. Does your weight affect the way you feel about yourself? no yes
13. Have any members of your family suffered from an eating disorder? no yes
14. On a scale from 1 to 10 (1 = no desire at all and 10 = strongly desire), how would you rate your desire to change your diet or behavior (lifestyle). Circle one choice below:
1 2 3 4 5 6 7 8 9 10

D. Medical History

1. Do you have a history of medical issues? no yes
If yes, what kind? _____
2. Have you had surgery before? no yes
If yes, for what? _____

E. Physical Activity Status

1. On how many of the **past 7 days** did you **exercise** or participate in sports activities for at least **20 minutes** that made you sweat and breathe hard, such as basketball, jogging, fast dancing, swimming laps, tennis, fast bicycling, or similar aerobic activities?

- 0) 0 days
- 1) 1 day
- 2) 2 days
- 3) 3 days
- 4) 4 days
- 5) 5 days
- 6) 6 days
- 7) 7 days

2. Do you exercise consistently? no yes

3. What do you do for physical activity? _____

4. Are you a member of a gym? (circle) no yes

If so, which one(s)? _____

5. Do you incorporate weight training to your exercise routine? (circle)

- no
- yes
- Sometimes
- N/A

General Health

1. How much sleep do you get each night, on average? _____ hours

Do you generally take naps during the day? no yes

2. Do you smoke cigarettes or have you ever smoked? no yes

How often and how many do you smoke?

3. Do you consume alcoholic beverages? no yes

If yes, how many beverages do you consume per day? _____

Do you binge drink? no yes

Are you an occasional drinker (birthdays, holidays, etc.)? no yes

NOTE: Is there anything else you would like to discuss with the Dietitian or Nutrition Counselor?
