

**Nutrition Assessment/Consultation Form**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone number: \_\_\_\_\_

Date of birth: \_\_\_\_\_

Primary care physician's name/phone number: \_\_\_\_\_

When was the last time you visited with your physician? \_\_\_\_\_

How would you rate your overall health?                      Excellent      Fair      Poor

Have you ever been diagnosed with any of the following (circle those that apply):

- |          |                     |                  |                             |
|----------|---------------------|------------------|-----------------------------|
| Diabetes | High Blood Pressure | High Cholesterol | Sleep apnea                 |
| Obesity  | Anorexia Nervosa    | Bulimia Nervosa  | Polycystic Ovarian Syndrome |

Other diagnoses: \_\_\_\_\_

Have you seen a registered dietitian in the past? If yes, when and why?  
\_\_\_\_\_

On a scale of 1 – 5, how ready are you to make lifestyle changes? (1 – not very; 5 very ready)

What are one or two things about your eating habits that you'd like to change?  
\_\_\_\_\_

What motivates you the MOST to make lifestyle changes?  
\_\_\_\_\_

Eating Behaviors:  
Do you skip meals? \_\_\_\_\_

How often do you dine out? \_\_\_\_\_

What type of restaurants do you frequent? \_\_\_\_\_

Who does the cooking and shopping? \_\_\_\_\_

Daily Food Choices:  
Breakfast: \_\_\_\_\_

# Victoria Shanta Retelny, RD, LD

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Lunch: \_\_\_\_\_

Dinner: \_\_\_\_\_

Snacks: \_\_\_\_\_

What medications and/or supplements do you currently take?

\_\_\_\_\_

\_\_\_\_\_

List the types of activities that you do regularly:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

How did you hear about my services? \_\_\_\_\_

Thank you!