# Nutrition Assessment

Name:______________________________________________ Date: ______________

Gender ☐ F ☐ M Date of Birth:____________________ Age: ______________

Phone: (h)______________ (c) ______________ Email: ______________________

Physician:__________________________ Referred by:__________________________

Primary Concern(s):______________________________________________________

Ancestral Background: ☐ African ☐ European ☐ Native American ☐ Mediterranean
☐ Asian ☐ Ashkenazi ☐ Middle Eastern ☐ Other

## Medical History

Personal Medical History: *(e.g. diabetes, depression, obesity, etc.)* ____________________

______________________________________________________________________

Family Medical History: *(e.g. diabetes, depression, obesity, etc.)* ____________________

______________________________________________________________________

Do you have any medical conditions that would prevent you from changing your current eating pattern? *(if so please list condition and explain below)* ______________________________________________

______________________________________________________________________

Substance History: ☐ smoking ☐ current ☐ past # Years____________________
☐ alcohol ☐ current ☐ past per week: ☐ 1-3 ☐ 4-6 ☐ 7-10 ☐ >10

Recreational Drug Use: ☐ current ☐ past type & frequency ____________________

Family History: __________________________________________________________

Troubling Symptoms: ______________________________________________________

## Weight History

Height: ________ Weight: ________Weight 6 months ago:_________ Weight 1 yr ago: ________ Usual weight range: __________

Highest adult weight:____________________ Lowest: ________________ Desired weight range? ______________

Weight fluctuations (>10 lbs.) ☐ Yes ☐ No

BMI __________________Waist circumference________________ Body fat %______________

Hip to waist ratio ________________________________________________________

## Lifestyle

**Stress & Coping:**

Daily stressors: *rate on a scale of 1 (lowest) to 10 (highest)*

Health________ Work _________Family________ Social _________Finances ________Other *(name)*________________

Stress/Coping Techniques:__________________________________________________

Comments: ______________________________________________________________

**Sleep Habits:**

Average number of hours per night: ☐ >10 ☐ 8-9 ☐ 6-8 ☐ <6

Sleep concerns: ☐ insomnia ☐ trouble falling asleep ☐ awakenings ☐ snoring ☐ awake unrefreshed

Comments: ______________________________________________________________

## Food & Nutrition History

Have you made any recent changes in your eating habits? ☐ Yes ☐ No

Describe: ______________________________

How would you describe your current diet? ☐ vegetarian ☐ vegan ☐ gluten-restricted ☐ no dairy

☐ food allergy/intolerances ______________ ☐ other ______________

Do you avoid any foods? ☐ Yes ☐ No If yes, describe: ______________

Do you crave any foods? ☐ Yes ☐ No If yes, describe: ______________

Do you grocery shop? ☐ Yes ☐ No Cook? ☐ Yes ☐ No If no, who does the cooking? ______________

Number of meals out per week: ☐ 0-1 ☐ 1-3 3-5 ☐ >5 meals per week

## Check all the factors that apply to your current lifestyle and eating habits:

- ☐ Love to eat
- ☐ Eat because I have to
- ☐ Fast eater
- ☐ Eat too much
- ☐ Emotional eater
- ☐ Negative relationship with food
- ☐ Erratic eating pattern
- ☐ Late night eating
- ☐ Eating in the middle of the night
- ☐ Time constraints
- ☐ Do not plan meals or menus
- ☐ Don't care to cook
- ☐ Reliance on convenience items
- ☐ Poor snack choices
- ☐ Travel frequently
- ☐ Challenges in obtaining healthy foods
- ☐ Significant other or family members don't like healthy foods
- ☐ Significant other or family members have special dietary needs or food preferences
- ☐ Confused about nutrition advice

## Physical Activity

Type/Frequency/Duration: *(eg: running 6 mph / 3 days a week / 1 hour runs)*

______________________________

Limitations to exercise: ______________________________

## Medications, Vitamins, Minerals, Herbs, & Other Supplements

*Please list all that you are currently taking - include dose, frequency & start date*

| **Name**<br>*Example: One a Day Multivitamin* | **Dose/Frequency**<br>*1 cap/once daily* | **Start Date**<br>*Jan 2008* |
|---|---|---|
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Other Information you would like to share: ______________________________

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# Medical Symptom/Toxicity Questionnaire

Name:________________________________________________________________Date: ___________________________

The toxicity and symptoms screening questionnaire identifies symptoms that help to identify the underlying causes of illness and helps you track your progress over time. Rate each of the following symptoms based upon your health profile for the past 30 days. If you are taking after the first time, record your symptoms for the last 48 hours ONLY.

**DIGESTIVE TRACT**

___Nausea or vomiting
___Diarrhea
___Constipation
___Bloated feeling
___Belching or passing gas
___Heartburn
___Intestinal/Stomach pain
Total __________

**EARS**

___Itchy ears
___Earaches, ear infections
___Drainage from ear
___Ringing in ears, hearing loss
Total __________

**EMOTIONS**

___Mood swings
___Anxiety, fear or nervousness
___Anger, irritability or aggressiveness
___Depressions
Total __________

**ENERGY/ACTIVITY**

___Fatigue, sluggishness
___Aptahy, lethargy
___Hyperactivity
___Restlessness
Total __________

**EYES**

___Watery or itchy eyes
___Swollen, reddened or sticky eyelids
___Bags or dark circles under eyes
___Blurred or tunnel vision (does not include near- or far-sightedness)
Total __________

**HEAD**

___Headaches
___Faintness
___Dizziness
___Insomnia
Total __________

**HEART**

___Irregular or skipped heartbeat
___Rapid or pounding heartbeat
___Chest pain
Total __________

**JOINS/MUSCLES**

___Pain or aches in joins
___Arthritis
___Stiffness or limitation of movement
___Pain or aches in muscles
___Feeling of weakness or tiredness
Total __________

**LUNGS**

___Chest congestion
___Asthma, bronchitis
___Shortness of breath
___Difficult breathing
Total __________

**MIND**

___Poor memory
___Confusion, poor comprehension
___Poor concentration
___Poor physical coordination
___Difficulty in making decisions
___Stuttering or stammering
___Slurred speech
___Learning disabilities
Total __________

**MOUTH/THROAT**

___Chronic coughing
___Gaggling, frequent need to clear throat
___Sore throat, hoarseness, loss of voice
___Canker sores
Total __________

**NOSE**

___Stuffy nose
___Sinus problems
___Hay fever
___Sneezing attacks
___Excessive mucus formation
Total __________

**SKIN**

___Acne
___Hives, rashes, or dry skin
___Hair loss
___Flushing or hot flashes
___Excessive sweating
Total __________

**WEIGHT**

___Binge eating/drinking
___Craving certain foods
___Excessive weight
___Compulsive eating
___Water retention
___Underweight
Total __________

**OTHER**

___Frequent illness
___Frequent or urgen urination
___Genital itch or discharge
Total __________

Grand Total___________

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## Key to Questionnaire

Add individual scores and total each group. Add each group scores and give a grand total.

Optimal is less than 10 Mild Toxicity: 10-50 Moderate Toxicity: 50-100 Severe Toxicity: over 100

# 3-Day Diet Diary Instructions

It is important to keep an accurate record of your usual food and beverage intake as part of your treatment plan. Please complete this Diet Diary for 3 consecutive days.

- Do not change your eating behavior at this time, as the purpose of this food record is to analyze your present eating habits.
- Record information as soon as possible after the food has been consumed.
- Describe the food or beverage as accurately as possible, e.g., milk (whole, 2%, nonfat); toast (whole wheat, white, buttered); chicken (friend, baked, breaded), coffee (decaffeinated with sugar and ½ & ½).
- Record the amount of each food or beverage consumed using standard measurements such as 8 ounces, ½ cup, 1 teaspoon, etc.
- Include any added items. For example: tea with 1 teaspoon honey, potato with 2 teaspoons butter, etc.
- Record all beverages, including water, coffee, tea, sports drinks, sodas/diet sodas, etc.
- Include any additional comments about your eating habits on this form (ex. Craving sweet, skipped meal and why, when the meal was at a restaurant, etc.)
- Please note all bowel movements and their consistency (regular, loose, firm, etc.)

## Diet Diary

Name:__________________________________________ Date: ____________________

**DAY 1**

| Time | Food/Beverage/Amount | Comments |
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Bowel Movements (#, form, color):________________________________________

Stress/Mood/Emotions: _____________________________________________

Other Comments:_________________________________________________

Other: _________________________________________________________

**DAY 2**

| Time | Food/Beverage/Amount | Comments |
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Bowel Movements (#, form, color):________________________________________

Stress/Mood/Emotions: ________________________________________

Other Comments:________________________________________

Other: ________________________________________

**DAY 3**

| Time | Food/Beverage/Amount | Comments |
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Bowel Movements (#, form, color):________________________________________

Stress/Mood/Emotions: ________________________________________

Other Comments:________________________________________

Other: ________________________________________

# Food Frequency Questionnaire (FFQ)

Name:________________________________________ Date: ______________________

| Food or Beverage | Daily | 1-2 x per week | 1-2 x per month | Never Eat this Food | Willing to Try this Food |
|---|---|---|---|---|---|
| Fruit | | | | | |
| Dried Fruit | | | | | |
| Fruit Juice | | | | | |
| Vegetables, raw | | | | | |
| Vegetables, cooked | | | | | |
| Vegetable Juice | | | | | |
| Vegetables, starchy: peas, corn, winter squash, sweet potato, etc. | | | | | |
| Grains: whole wheat, rye, barley, oats, kamut, spelt | | | | | |
| Gluten Free (GF) Grains: rice, millet, quinoa, amaranth, buckwheat, corn | | | | | |
| Grain Products: bread, rolls, bagels, etc. | | | | | |
| GF Products: bread, rolls, bagels, etc. | | | | | |
| Cereals: low sugar, high fiber | | | | | |
| Cereals: high sugar | | | | | |
| Pasta | | | | | |
| Pasta: GF types | | | | | |
| Beans, Humus, Lentils | | | | | |
| Veggie Burgers | | | | | |
| Soups | | | | | |
| Soy Foods: miso, tofu, tempeh | | | | | |
| Edamame, Soy Milk, etc. | | | | | |
| Eggs | | | | | |
| Egg Whites | | | | | |
| Fish | | | | | |
| Shellfish | | | | | |
| Poultry | | | | | |
| Red Meat | | | | | |
| Frozen or Convenience Meals | | | | | |
| Cheese | | | | | |
| Yogurt | | | | | |
| Milk, skim | | | | | |
| Milk, 2% | | | | | |
| Milk, whole | | | | | |
| Non-Diary Milks: almond, hemp, rice, soy | | | | | |
| Protein Powders or Greens | | | | | |

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| Drinks<br>Type: | | | | | |
| Energy Bars Brand: | | | | | |
| Nuts or Seeds | | | | | |
| Nut Butters: almond, cashew, peanut | | | | | |
| Avocado | | | | | |
| Olives | | | | | |
| Oils<br>Types: | | | | | |
| Butter | | | | | |
| Margarine/Spreads<br>Types: | | | | | |
| Salad Dressings | | | | | |
| Mayonnaise | | | | | |
| Mustard | | | | | |
| Ketchup or Salsa | | | | | |
| Soy Sauce | | | | | |
| Frozen Deserts: ice cream, frozen yogurt, etc. | | | | | |
| Muffins, Cakes, Cookies, Pastries, Donuts, etc. | | | | | |
| Chips: potato, corn, etc. | | | | | |
| Chocolate | | | | | |
| Candy | | | | | |
| Alcohol: wine, beer, spirits | | | | | |
| Coffee: regular or decaf | | | | | |
| Tea: black, green, white, decaf, herbal | | | | | |
| Sodas or Fruit Drinks | | | | | |
| Diet Sodas | | | | | |
| Water | | | | | |
| Other Beverages<br>Type: | | | | | |
| Sweeteners<br>Type: | | | | | |
| Artificial Sweeteners<br>Type: | | | | | |
| Salt | | | | | |
| Pepper | | | | | |
| Seasonings: | | | | | |
| Other Foods Frequently Consumed | | | | | |