DCH Diabetes and Nutrition Education Center

Nutrition Assessment

Name ____________________________Date of birth__________________ Date ____________________

Reason for visit today: ____

Age ___________ Height ___________ Weight ________ Usual Body Weight __________

Are you interested in: Losing weight _______ Gaining weight _______ maintaining weight _______

List other medical conditions you have: ____

____

Current Medications:____

Are you employed? Yes___ No___ Are you retied? Yes____ No____

What is (was) your occupation?____

From whom do you get support from? ___Family ___ Co-workers ___No-one

My stress level is: _____Low_____ Moderate _____High

How do you handle stress? ____

Do you use tobacco? ____Cigarette ___Cigar ___Chewing ___None

Do you exercise regularly? Y□ N What type and how often: __________________

Do you do your own food shopping? Y□ N If not, who does? _________________________

Do you cook your own meals? Y□ N If not, who does?__________________________

How often do you eat out? ____

Give a sample of your meals for the last 24 hours including drinks:

Breakfast Time: ________	**Lunch** Time: ________	**Dinner** Time: ________
______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	______________________
Snack Time: ________	**Snack** Time: ________	**Snack** Time: ________
______________________	______________________	______________________
______________________	______________________	______________________