NUTRITION ASSESSMENT INTAKE

Tara Rochford
Registered Dietitian Nutritionist
trochfor@butler.edu
317-940-6108

Please complete this nutrition assessment form and send to the dietitian 24 hours prior to your first session. Completing this form will save time during the session and allow us to maximize our time together.

Name: _____

Date of Birth: _____ Age: _____

Address: _____

_____

Phone Number: _____ Email Address: _____

Referred by: __Butler Clinician/Healthy Horizons __Outside Clinician __ Counseling Center __Website __On-Campus Information/Presentation __Family Member __Friend/Co-Worker __Self __Other

Primary reason for nutrition counseling:

_____

_____

Medical History

Medical and surgical history:

_____

_____

Current medications/supplements/herbals:

_____

_____

Family medical history:

_____

_____

Height: _____ Current Weight: _____

Has your weight been stable for more than a year? If not, please explain any changes:

_____

_____

Diet History

How would you describe your eating habits: _____

_____

Previous diets you have tried: _____

_____

Food allergies: _____

Do you follow any special diet or eating habits (e.g. religious restrictions, vegetarianism, etc.)? _____

_____

Do you cook? If yes, how often? _____

How many times per week (or month) do you eat at restaurants or consume take out or fast food? Please do not include eating in the dining halls. _____

_____

How many times per day do you eat (meals and snacks included)? _____

_____

What liquids/beverages do you drink on a daily or weekly basis (e.g. water, soda, alcohol, etc.)? _____

_____

FOR STUDENTS ONLY:

Are you on a meal plan? Yes _____ No _____

Where do you eat on campus? Dining Halls _____ Fast food/ C-Club _____ Self-Preparation _____

Room/Apartment ____ Greek House _____ Other____

*If possible please keep a food diary for 3 days and bring it to your appointment.

It may be helpful to do 2 week days and 1 weekend day*

LIFESTYLE QUESTIONS

Do you currently use tobacco products? Yes___ No___

Please describe your exercise routine and/or amount of physical activity (type, frequency, time): _____

_____

_____

How many hours of sleep do you get per night? _____

How do you feel about your body? _____

_____

Please provide any additional information that you feel would be helpful for the dietitian to know: _____

_____

_____

PLEASE CIRCLE HOW CONFIDENT YOU ARE THAT YOU CAN CHANGE YOUR EATING BEHAVIORS:

NOT VERY CONFIDENT VERY CONFIDENT

1 2 3 4 5 6 7 8 9 10

PLEASE CIRCLE HOW MOTIVATED YOU ARE THAT YOU CAN CHANGE YOUR EATING BEHAVIORS:

NOT VERY MOTIVATED VERY MOTIVATED

1 2 3 4 5 6 7 8 9 10