CompleteHealth
INTEGRATIVE WELLNESS CLINIC

Nutrition Assessment

Name:

Reason(s) for Nutrition Consult:

Food and Nutrition-Related Goals:

Overall Health Goals:

Current Eating Pattern
(Include what is eaten on a typical day, details related to dining out, portion sizes, convenience items, etc)

	Typical Foods Consumed
Breakfast Approx. Time:	
Lunch Approx. Time:	
Dinner Approx. Time:	
Additional Meals Approx. Time(s):	
Daytime Snacks Approx. Time(s):	
Nighttime Snacks Approx. Time(s):	

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Does your eating pattern change on the weekends? If so, please describe.

_____

_____

List any vitamins or supplements you take on a regular basis:

_____

_____

Habits, Choices, and Situations Impacting Nutrition

If you could change three things about your health and nutrition habits, they would be:

1. _____
2. _____
3. _____

The biggest challenge(s) to reaching your nutrition and health goal is-are:

_____

_____

In the past, what techniques and/or behaviors have you used to reach your nutrition goals:
(Examples: healthy eating & exercise, specific diets, detoxes, cleanses, skipping meals, fasting, weight loss pills, etc)

_____

_____

The nutrition/eating habits you are most pleased with are:

_____

_____

_____

Please list any non-medical dietary limitations you have (dislikes, cultural, or religious/ethnic preferences):

_____

_____

Do you have any specific food rules or rituals you follow? Yes ___ No ___
If yes, please explain. _____

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Do you have any food cravings? Yes ___ No ___

If yes, do food cravings generally happen at specific times or related to specific situations. Please explain.

_____

_____

List any limitations related to time, budget, and food shopping experience or kitchen constraints:

_____

_____

_____

Do you ever worry that you have lost control over how much you eat? Yes ___ No ___
Please list any stressors that you feel impact how you eat:

_____

_____

Please list any additional social or environmental factors that you feel impact how you eat:

_____

_____

On average, how many hours of sleep do you get per on weekdays? _____ Weekends? _____

Please describe your typical exercise habits

Type of Exercise	Days Per Week	Duration of Exercise

How often do you have a drink* containing alcohol?
(* 1 drink is equal to: 12 ounces of beer, 5 ounces of wine or 1.5 ounces of liquor.)

___ Never ___ Monthly or less ___ 2-4 times per month ___ 2-3 times per week
___ 4 or more per week

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How many standard drinks containing alcohol do you have on a typical day?

___ 1-2 ___ 3-4 ___5-6 ___ 7-9 ___ 10 or more

Nutrition and Digestive Health

Do you have any known food allergies or sensitivities? Yes ___ No ___
Please list any foods related to the digestive or allergy issues and describe your body's reaction.

_____

_____

Circle any of the symptoms below that you experience frequently:

Heartburn	Gas	Bloating	Stomach Pains
Nausea/Vomiting	Diarrhea	Constipation	

The food/nutrition questions I would like to make sure to ask are:

_____

_____

_____