NUTRITIONAL ASSESSMENT

NAME:_________________________       DATE:____________

1. Do you have any food allergies?  ____yes   ____no
2. List your food allergies.______________________________________________________________
3. List the foods you dislike.____________________________________________________________
4. List the foods you have problems with and what types of problems you have.________________________
5. How many meals do you eat daily?  ______
   How many of these meals do you eat alone?  ______
6. Do you feel like you eat a well balanced meal at least once a day?  _____
7. List the number of protein foods you eat each day such as meat, eggs, beans.________________________
8. List the number of servings of vegetables you have daily. _____________
9. List the number of servings of fruit or fruit juice you have daily. ______
10. How many 8 oz. cups of water do you drink daily? ______
11. How many cups of tea, or coffee do you drink a day?  ____________
12. Do you drink alcoholic beverages? ______How often?________
13. Do you sometimes forget to eat or drink? _______________________________________________
14. Do you have your own teeth?  __________________________
15. Do you have dentures or a partial plate? ______Describe_______________________________
   ______________________________________________________________________________________
16. Do you have difficulty chewing or swallowing? ________________________________
17. What help is provided at meal time for you? (example: meat is chopped) _________________
18. Have you lost or gained more than 6 pounds in the last 6 months?____ Describe______________________________
19. What is your current weight? _____________________________
20. How tall are you? __________________
21. Do you walk regularly? ______ About how many minutes of walking do you do a day? (around the home can be counted)__________________
22. Do you have difficulty with constipation? ____If yes, how do you treat it?__________________________
23. Do you have any pressure ulcers or opened areas on your skin? ____ Describe__________________________