Registered Dietitian

Assessment Form

CLIENT INFORMATION

Name:		Phone:
Province or State	Date of Birth	Email:

MEDICAL INFORMATION

Medications:	Supplements:

Medical history: *Please indicate all that apply.*

- ❑ High cholesterol
- ❑ Heart disease
- ❑ Osteoporosis
- ❑ Diabetes, prediabetes
- ❑ Fatty liver
- ❑ Gout
- ❑ Celiac disease or gluten intolerance
- ❑ Digestive diseases (define):

Symptoms: *Please indicate any of the following symptoms you may experience in the last few weeks.*

- ❑ Constipation
- ❑ Diarrhea
- ❑ Stomach pain
- ❑ Excess gas
- ❑ Acid reflux
- ❑ Bloating
- ❑ Poor energy or concentration

Laboratory values: *If you would like me to review any lab work, please request a copy from your doctor.*

Please indicate if any of the following lab values are abnormal

- ☐ Total Cholesterol
- ☐ Triglycerides
- ☐ LDL-Cholesterol
- ☐ HDL-Cholesterhol
- ☐ Non-HDL cholesterol
- ☐ Apo-B
- ☐ GFR (kidney function)
- ☐ Fasting blood glucose
- ☐ Hemoglobin A1c
- ☐ CRP (C-reactive protein)
- ☐ Sodium
- ☐ Potassium
- ☐ Vitamin D
- ☐ Vitamin B12
- ☐ HgB (hemoglobin)
- ☐ Hct (hematocrit)
- ☐ MCV (mean cell volume)
- ☐ Folate
- ☐ TIBC (iron binding capacity)
- ☐ Transferrin
- ☐ Iron

HEALTH GOALS

What is your nutrition goal?	What would change in your life if you were able to achive this goal?
	What challenges do you face in meeting this goal?

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PHYSICAL INFORMATION

Height:	**Current weight**:	Heaviest weight as an adult (age):
	Desired weight:	Lightest weight as an adult (age):
Tell me more about your person weight story:		

LIFESTYLE INFORMATION

Activity: *Tell me about your current physical activity*

Activities I do:	Sessions / week	Minutes / session	Intensity (easy, moderate, vigorous)

Stress: On a scale of 1 to 10, how stressed are you? 1 is very low stress and 10 is highly stressed.

1 2 3 4 5 6 7 8 9 10

DIETARY FACTORS

Food allergies or intolerances:		Food dislikes:	
How many meals and snacks do you have each day?		What snacks to you choose?	
Do you drink alcohol?	How many each week?	Do you eat out?	Which restaurants?

What type of dietary plan would you consider to help meet your health goals:

- ❑ Lower carbohydrate diet
- ❑ Ketogenic diet
- ❑ High protein diet
- ❑ Mediterranean diet
- ❑ Vegetarian or vegan diet
- ❑ Cleanse or detox diets
- ❑ Paleo diet
- ❑ Some plant-based meals
- ❑ No particular diet

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Date: _____ Day of the week: _____ Did you work today? No

	Details about what you ate	Amount and portion size
Meal: Time of day:		
Meal: Time of day:		
Meal: Time of day:		
Meal: Time of day:		
Meal: Time of day:		

Comments about your day. (exercise, stress, travel)

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