Cooley Dickinson Medical Group

Nutritional Assessment

CDMG 2507 Rev 7/17

Name:

D.O.B.

Med. Rec.#

Name:_____ Date of Birth:_____

What is your occupation? _____

What hours and days do you work? _____

What medical conditions do you need nutritional counseling for?☐ Diabetes ☐ High cholesterol

☐ Hypertension ☐ Weight Management ☐ Eating Disorder ☐ Other _____

Do you have a history of an eating disorder or think you may have an eating disorder? If yes, please explain:

_____

What medications/supplements do you use? (Please include dosage)_____

_____

_____

NUTRITION HISTORY Are you presently or have you in the past, followed a modified diet?

☐ Yes ☐ No If yes, please indicate type _____

Do you live: ☐ alone ☐ with spouse ☐ other _____

Who prepares meals in your house? ☐ self ☐ spouse ☐ other _____

Who does the food shopping? ☐ self ☐ spouse ☐ other _____

How many times do you eat out in a week? _____

At what type of restaurant? ☐ Fast food ☐ Buffets ☐ Sit-down ☐ Coffee/desert ☐ other _____

Do you have any problems with the following: ☐ Chewing ☐ Constipation ☐ Diarrhea ☐ Nausea

☐ Vomiting ❑ Headache/migraine ❑ depression/mood disorder ❑ IBS ❑ GERD/acid reflux

❑ Hypoglycemia/low blood sugar ❑ Skin disorder (rash, acne, eczema) ❑ Gas/bloating ❑ Swallowing

❑ Other _____

Do you have any food allergies? ☐ No ☐ Yes, describe_____

WEIGHT HISTORY Have you experienced any recent weight changes? ☐ Yes ☐ No

If yes, ❑ Intentional or ❑ Unintentional How many pounds in what period of time? _____

Please indicate your highest weight as an adult: Weight_____ Age_____

Please indicate your lowest weight as an adult: Weight_____ Age_____

What would you consider to be a healthy weight for you? _____

Does stress affect your eating patterns? ☐ No ☐ Yes _____eat more _____eat less

Are you interested on working on your weight now? ☐ No ☐ Yes _____

PHYSICAL ACTIVITY HISTORY

Do you have any disabilities that limit your physical activity?

☐ No ☐ Yes, describe _____

What type of exercise do you do on a regular basis? ☐ walking ☐ biking ☐ No regular exercise

☐ swimming ☐ Dancing ☐ aerobics ☐ other _____

How often, how long, and when do you exercise? _____

What other physical activities do you do regularly as part of your daily living?

☐ Housework ☐ Gardening ☐ Farming ☐ Climbing Stairs ☐ Other _____ ☐ None

Are you interested in becoming more physically active? ☐ No ☐ Yes

PREGNANCY AND FERTILITY

Are you: □ ☐ Pre-menopausal ☐ □ Menopausal ☐ □Post-menopausal □☐ N/A
Are you pregnant? ☐ □Y ☐ □N When are you expecting? _____
Are you planning on becoming pregnant? ☐ □ Y ☐ □N
Have you been pregnant before? ☐ □Y ☐ □ N How many times? _____
Do you have any children? ☐ □Y ☐ □N ages: _____
Are you aware if the impact of diabetes on pregnancy? ☐ □Y ☐ □N
Are you using birth control? ☐ □Y ☐ □N Please specify: _____

FOOD INTAKE SUMMARY

In the space below, please record what you typically eat in a 24-hour period. Include all snacks and beverages.

Breakfast	**Lunch**	**Dinner**
Time:	Time:	Time:
Morning Snack	**Afternoon Snack**	**Evening Snack**
Time:	Time:	Time:

Beverages: (How much and how often)

Juice:
Soda:
Water:
Caffeine (coffee, tea, energy drinks):

How many alcoholic drinks do you have per week?
_____

What kind? ☐ Beer ☐ Wine ☐ Mixed drinks

Completed by _____ Print name _____

Relationship to patient _____ Date _____

CLINICIAN ASSESSMENT SUMMARY:

Clinician Signature: _____ Print:_____ Date:_____ Time:_____