



Hunterdon Health

Center for Nutrition & Diabetes Management

Wescott Medical Arts Building

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Nutrition Self-Assessment

Please fill out all of the information on this form and bring it to your nutrition appointment.

(Please use a pen. Do not use pencil.)

Name: _____ Date of Birth: _____ Today's Date: _____

Primary Care Physician: _____

The most important things I want to learn or discuss today:

1. _____

2. _____

Have you had previous nutrition education? Yes No

When? _____ Where? _____

List your vitamins/supplements _____

List any food and/or drug allergies _____

Exercise:

Do you exercise regularly? Yes No Type of exercise: _____ How often? _____

List any limitations with exercise: _____

Intake History:

Do you feel constantly concerned about eating or fell uncomfortable in social situations related to food? Yes No Please explain: _____

Do you drink alcohol? Yes No If so, how much? _____

Who prepares your meals? _____

How many times a week do you eat away from home? _____

Fast Food Restaurant Take Out Other _____

Based on one day:

How much dairy do you consume? _____ How many vegetables? _____ Fruits? _____

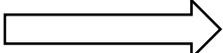
What are your main beverages and how much? _____

Please list any trigger foods that make you overindulge: _____

Please answer these statements below about your household in the last 12 months:

We worried that our food would run out before we got money to buy more. Often Sometimes Never

The food we bought just didn't last, and we didn't have money to get more. Often Sometimes Never

Please fill out a Food Diary on the next page. 

Name: _____ Date of Birth: _____

Height: _____ Current Weight: _____

Usual Body Weight: _____ Goal Weight: _____

Please record your food intake. What kind of food? How much food?

BREAKFAST TIME: _____	MORNING SNACK TIME: _____
LUNCH TIME: _____	AFTERNOON SNACK TIME: _____
DINNER TIME: _____	EVENING SNACK TIME: _____

_____ RD DATE: _____

Notes/Comments: _____

Daily Activities: _____
