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Initial Assessment Form

Date: _____

Personal Information

Name: _____ Date of Birth: _____ ❑ Male ❑ Female

Personal Health Information:

Height: _____ Weight: _____

Usual Weight: _____ Weight History: _____ Bowel Habits: _____

Blood pressure (If known):_____(If concerns, please visit pharmacy for a measurement)

- Do you have any other health concerns? _____
- Are you taking any medication? ❑ No ❑ Yes List: _____

  _____
- Have you ever seen a dietitian in the past? _____
- What are your goal(s) and expectations in meeting with a dietitian? _____

  _____
- Do you have any food allergies, sensitivities or intolerances? ❑ No ❑ Yes

  If yes, please list and describe the symptoms: _____

Lifestyle Information

- Do you drink alcohol? ❑ No ❑ Yes # drinks/week _____
- Do you smoke? ❑ Yes ❑ No # packs/day _____ # years _____
- Do you exercise? ❑ No ❑ Yes What type and how many times per week? _____
- Do you take any supplements/vitamins/minerals? ❑ No ❑ Yes If yes, what? _____

  _____
- What is your general eating pattern? _____
- How many meals do you eat away from home each week? Breakfast: _____ Lunch: _____ Supper: _____
- How is your cooking? _____ Where do you normally shop for food? _____
- Who does the shopping/cooking? _____

Food Frequency Questionnaire

How many times do you consume the following per day or per week (please specify the frequency as "/day" or "/week"):

Coffee/tea: _____ Juice/pop: _____ Water: _____ Added salt: _____
Milk: _____ Yogourt: _____ Cheese: _____ Salty foods: _____
Dairy (other): _____ Red Meat: _____ Processed meats: _____ Butter: _____
Fish: _____ Poultry: _____ Nuts: _____ Legumes: _____
Fruit: _____ Vegetables: _____ Grains: _____
What is your favourite food?: _____

Diet History Day 1

Enter as much information as possible. Brand, quantity or portion size

Time	Meal	Foods/Beverages/Amounts
	Breakfast	
	AM Snack	
	Lunch	
	PM Snack	
	Supper	
	Evening Snack	

Nutrition Care Plan and Follow-up

Nutrition Care Plan:

Follow Up Plans: