



Nutrition Initial Assessment

Client Name: _____ Date: _____

Referral source: _____ Referring Physician: _____

Phone: _____ Email: _____

Home Address: _____

Would you like to be added to the monthly newsletter distribution list? Yes / No

What are the goals that you are trying to achieve with your initial appointment?

Past Medical History: (check all that apply)

- | | | |
|---|--|---|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Hypothyroidism |
| <input type="checkbox"/> Cardiovascular Disease | <input type="checkbox"/> Dialysis | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Anxiety/Depression |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Gout | <input type="checkbox"/> Anorexia |
| <input type="checkbox"/> High Triglycerides | <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Binge Eating |
| <input type="checkbox"/> Type I Diabetes | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Bulimia |
| <input type="checkbox"/> Type II Diabetes | <input type="checkbox"/> Stroke | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Diverticulosis | <input type="checkbox"/> Acid Reflux | <input type="checkbox"/> Bone Density Scan |
| <input type="checkbox"/> Joint Pain | <input type="checkbox"/> Gallbladder Disease | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Asthma | <input type="checkbox"/> Other: _____ |

Past Surgical History: (include type and date)



Medications: (list all currently taking and what you are taking them for)

| Name | Purpose |
|------|---------|
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |

List Medication Allergies: _____

List Food Allergies: _____

List Food Intolerances: _____

Are you on any dietary or fluid restrictions? YES / NO
If so, what are they? _____

Vitamin/Mineral/Herbal Supplements: (list all types taken and quantities)

Family Medical History: (check all that apply)

- Cancer
- Cardiovascular Disease
- Gout
- Diabetes
- Stroke
- High Cholesterol
- Hypertension
- Obesity
- Osteoarthritis
- Osteoporosis



Demographics/Weight History:

Age: _____ Height: _____ Current Weight: _____

Date of Birth: _____

Lowest Adult Weight: _____

Highest Adult Weight: _____

Usual Body Weight: _____

Complete the following questions if you are struggling with your weight.

Has your weight changed in the last year? YES / NO

If yes, then how? _____

At what age did you begin struggling with your weight? _____

At what age did you begin dietary interventions to lose weight? _____

List environmental triggers leading to weight gain? _____

What do you think is a realistic weight for you? _____

How long has it been since you were at that (realistic) weight? _____

Most weight lost with dieting? _____

Previous weight loss attempts: (list the types of diets, medications, and surgeries tried)

What is the reason you usually discontinue a diet? _____



Have you ever used vomiting, laxatives, or diuretics to lose weight? YES / NO

If yes, which one and how long ago? _____

Have you had weight loss surgery before? YES / NO

If yes, which one and when? _____

Have you seen a registered dietitian or nutritionist before? _____

Exercise History:

Do you exercise now? YES / NO

If yes, what, how often, and how long do you exercise? _____

Is there anything that prevents you from being physically active? _____

Are you committed to incorporating physical activity into a long term healthy lifestyle program? YES / NO

If yes, how do you plan on exercising? _____

Current Eating Habits/Diet Recall: (list the foods and drinks that you have consumed in the past 24 hours)

| Breakfast | Snack | Lunch | Snack | Dinner | Snack |
|-----------|-------|-------|-------|--------|-------|
| | | | | | |



Who does the grocery shopping? _____

Who prepares meals in your home? _____

How often do you eat sweets? _____

How often do you eat fried foods? _____

How often do you eat snack food such as chips? _____

Do you use any meal replacement products (drinks, bars, formulas)? YES / NO

If yes, than list the types and how often you take them. _____

Food Frequency

How much water do you drink per day? _____

How often and what type of coffee or tea do you drink? _____

How often and what type of soda do you drink? _____

How often and what type of juice do you drink? _____

How often and what type of milk do you drink? _____

How often and what types of vegetables do you eat? _____

How often and what types of fruits do you eat? _____

How often and what types of dairy products do you eat? _____

How often and what types of meat do you eat? _____

How often and what types of grains do you eat? _____

How often and what type of alcohol do you drink? _____

How often and what type of alcohol do you drink? _____

Do you smoke? YES / NO

If yes, how often and how much? _____

How many meals do you eat away from home on weekdays?

How many breakfasts? _____ Lunches? _____ Evening meals? _____

How many meals do you eat away from home on weekends?

How many breakfasts? _____ Lunches? _____ Evening meals? _____



List restaurants where you often eat:

Is there anything else that you want the dietitian to know?



Goals Worksheet

1. _____

2. _____

3. _____

Notes: _____



**SO Nutrition, LLC
21815 Oak Park Trails Drive
Katy, TX 77450**

**Acknowledge of Review of
Notice of Privacy Practices**

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

I submit my email address to be used for a mailing list for SONutrition.com solely. I understand that my email will only be used in connection with SONutrition.com and will not be sold to any company or individual.

Signature of Patient

Email address:

Date



**SO Nutrition, LLC
21815 Oak Park Trails Drive
Katy, TX 77450**

SIGNATURE ON FILE

- I authorize the release of any medical or other information necessary to process this claim.
- I authorize the payment of medical benefits to SO Nutrition LLC for services provided.
- I understand that I am responsible for my bill including any co-pay or co-insurance or deductible under my policy.
- If I am not insured, or my Insurance Company will not authorize or pay for this visit, I understand that I am responsible for my bill and that your cash pay office visit fee is \$66.00 per 30 minutes.
- I understand that the policy of this office is to provide at least 24 hours notice in the event that I must cancel an appointment, however, if I "NO SHOW" for an appointment I will be liable to pay a \$50.00 fee.
- I permit a copy of this authorization to be used in place of the original.

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE

DATE