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)

☐ Cancer	☐ Kidney Disease	☐ Hypothyroidism
☐ Cardiovascular Disease	☐ Dialysis	☐ Anxiety
☐ Hypertension	☐ Liver Disease	☐ AnxietyDepression
☐ High Cholesterol	☐ Gout	☐ Anorexia
☐ High Triglycerides	☐ Osteoarthritis	☐ Binge Eating
☐ Type I Diabetes	☐ Osteoporosis	☐ Bulimia
☐ Type II Diabetes	☐ Stroke	☐ Anemia
☐ Diverticulosis	☐ Acid Reflux	☐ Bone Density Scan
☐ Joint Pain	☐ Gallbladder Disease	☐ Sleep Apnea
☐ Back Pain	☐ Asthma	☐ 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 change your weight? _____

List environmental triggers leading to weight change? _____

_____

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

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

Most weight change with trying? _____

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

_____

_____

_____

_____

_____

What is the reason you usually discontinue a intervention? _____

_____

_____

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? _____

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