LifeHelp Nutrition and Diabetes Center
Medical Nutrition Therapy Assessment Form

Today's Date: _____

Name: _____ Date of Birth: _____

Address: _____ City/Zip: _____

Home Phone: _____ Other Phone: _____

Insurance Carrier: _____

Have you ever received diet education before? No ☐ Yes ☐

When? _____ Where? _____

Health History

Please list any medical conditions: _____

_____

Please list any medications or non-prescription drugs you may be taking:

_____

_____

Please list any herbal supplements or vitamins you may be taking:

_____

_____

Do you smoke? Yes ☐ (packs per day_____) Never ☐ Quit ☐ (When?_____)

Social History

Present Occupation: _____ Retired ☐

Hours per week: _____ Night shift? Yes ☐ No ☐

Do you have any possible barriers to learning? Yes ☐ No ☐

Hearing: ☐ Visual: ☐ Language: ☐ Education: ☐ Other: _____

How many hours of TV do you watch daily? _____ Computer use daily/hrs: _____

LifeHelp Nutrition and Diabetes Center
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(727) 820-7910

St. Anthony's Hospital
BayCare Health System

LifeHelp

Nutrition History

Height: _____ Weight: _____

Please describe any recent change in your weight: _____

_____

Are you following any meal plan at this time? No ☐ Yes ☐ Explain: _____

_____

Do you eat breakfast? Yes ☐ No ☐ Do you frequently skip meals? Yes ☐ No ☐

How many meals do you eat per day? _____ Snacks? _____

Rank your reasons for eating (1 low–5 high):

Mealtime _____ Hunger _____ Emotional _____ Boredom _____ Social _____

Are you a vegetarian? Yes ☐ No ☐ How long have you been a vegetarian? _____

Please circle the items that are INCLUDED in your current dietary intake:

Beef Poultry Fish Eggs Milk Dairy-Other (Yogurt/Cheese)

Soy/Tofu Nuts

Do you have any food allergies or intolerances? _____

_____

_____

Are there any foods that you avoid or absolutely don't eat? _____

_____

How many meals on average, do you eat outside the home per week? _____

Favorite (frequent) restaurant(s): _____

Location: _____

Favorite menu items: _____

_____

Do you drink soda? Yes ☐ No ☐ Regular or Diet? _____ Total # fl. oz. per day _____

Do you drink coffee? Yes ☐ No ☐ Total # fl. oz. per day _____

Do you drink alcohol? Yes ☐ No ☐

Type/Frequency: Beer ☐ Wine ☐ Liquor ☐ 1-3/wk ☐ 1-2/day ☐ 3+/day ☐

Do you typically eat when you are: sad ☐ stressed ☐ anxious ☐

Food cravings: Do you prefer SWEETS or SALT? Examples? _____

Who is responsible for most of the food shopping? _____

Who is responsible for most of the cooking? _____

Exercise and Personal Habits

Do you exercise? Yes ☐ No ☐

What type(s)? (Walking, Bicycling, Swimming, Weight Training, Other) Please list below:

Type(s):	# Days/Week:	Intensity (low 1-5 high):	Duration (min):
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Have you ever been told by a physician to limit exercise for health reasons? Yes ☐ No ☐

Do you have any medical conditions that prevent you from exercising? Yes ☐ No ☐

If yes, please describe: _____

_____

Do you enjoy exercise? Yes ☐ No ☐

Behavior Change

Goals for nutrition counseling include: _____

_____

What can I do to help you achieve your goals? _____

_____

_____

Do you have any specific or particular QUESTIONS that you need/want answered?

_____

_____

_____

Patient Signature: _____ Date _____

Reviewed with patient by _____ Date _____

24 Hour Diet Recall

Please include a detailed summary of at least one day of actual dietary intake, including beverages.
Please circle: Monday Tuesday Wednesday Thursday Friday Saturday Sunday

Quantity/ Portion Size (oz, cup, Tbsp)	Type of Food (Describe)	Preparation Method (baked, fried, broiled)	Hunger Rating 1= starved 10= stuffed Before/After Eating	

Additional Comments:

Please check your answers. (Fill in the total quantity for daily intake.)	Rarely	1-2x/week	3-4x/week	Daily (Quantity)
How often do you:				
Eat two or more fruits a day (excluding juice)?				
Eat more than three vegetables a day?				
Drink six ounces of fruit juice?				
Choose whole grains when selecting grains, cereals, pasta?				
Eat at least one cup of pasta, rice, noodles?				
Eat white/refined bread, rolls, bagels?				
Eat muffins, biscuits, croissants, donuts?				
Put butter or margarine on breads, rolls, pasta?				
Eat red meat?				
Eat chicken, turkey, eggs?				
Eat the skin on turkey/chicken?				
Eat legumes/beans (kidney, chick peas, navy)?				
Eat fish (excluding shellfish)?				
Eat peanut butter, nuts?				
Drink one cup of milk (nonfat, 1%, 2%)?				
Consume soy products: soymilk, tofu, tempeh?				
Eat one ounce of cheese?				
Eat potato, tortilla or fried snack chips?				
Eat brownies, cookies, cake, chocolate?				
Drink regular and/or diet soda? (please circle type)				
Drink coffee and/or tea?				
Drink alcoholic beverages (beer, wine, liquor)?				