Nutrition Assessment

Name:	**Date of Birth:** **Phone:**	
Today's Date:	**Select One:** Student ☐ Faculty ☐ Staff ☐ Private ☐	**NetID:**
If you are a student, what is your classification: Freshman ☐ Sophomore ☐ Junior ☐ Senior ☐ Graduate Student ☐		

Please select your gender:

Male ☐	Female ☐	Non-Binary/Third Gender ☐	Prefer not to say ☐

Which of the following best describes you?

☐ Black or African American
☐ Asian or Pacific Islander
☐ White or Caucasian
☐ Hispanic or Latino
☐ Native American or Alaskan Native
☐ Multiracial or Biracial
☐ A race/ethnicity not listed here

Reason(s) for Nutrition Consult:

Food and Nutrition-Related Goals:

Do you have any of the following medical conditions?

☐ Diabetes
☐ High Blood Pressure
☐ High Cholesterol
☐ Kidney Disease
☐ Heart Disease
☐ Other

List any medications or vitamin/mineral supplements you take on a regular basis:

Weight History

Height: _____ Current Weight: _____

Have you had any recent changes in your weight that you are concerned about? ____ Yes ____No

If yes, please explain: _____

Please answer yes/no to the following questions:

Do you make yourself sick because you feel uncomfortably full? ____ **Yes** ____**No**
Do you worry you have lost control over how much you eat? ____ **Yes** ____**No**
Have you recently lost more than 15 pounds in a three-month period? ____ **Yes** ____**No**
Do you believe yourself to be fat when others say you are too thin? ____ **Yes** ____**No**
Would you say food dominates your life? ____ **Yes** ____**No**

For each statement, please tell me if it was often true, sometimes true, or never true:

Within the past 12 months I was worried about whether my food would run out before I got money to buy more.		
Often true	Sometimes true	Never true

Within the past 12 months the food I bought just didn't last and I didn't have the money to get more.		
Often true	Sometimes true	Never true

Please select the resources you are familiar with:

☐	Bully's Closet and Pantry
☐	Block by Block Meal Program
☐	SNAP (Supplemental Nutrition Assistance Program)
☐	Peter's Rock Food Pantry
☐	St. Joseph Food Pantry

What food/nutrition concerns would you like to make sure the dietitian addresses during the visit: