



Nutrition 101, LLC
"Nutrition Made Simple"
Client Assessment Questionnaire

Demographic Data

Name _____ Date _____
Address _____ Home # _____
_____ Office # _____
E-Mail _____ Cell# _____
Sex: M F Age: _____ Birth date _____ Height _____ Weight _____

Health History

1. What medical concerns (e.g., pregnancy), if any, do you have at the present time?

2. Indicate with you have any of the following problems:

Cancer	___yes ___no	High Blood Pressure	___yes ___no
Diabetes	___yes ___no	Osteoporosis	___yes ___no
Heart Disease	___yes ___no	Thyroid Disorder	___yes ___no
High Cholesterol	___yes ___no	Other	___yes ___no

3. Do you have complaints about any of the following?

_____Appetite	_____Diarrhea	_____Sudden Weight Change
_____Chewing or Swallowing	_____Edema	_____Stress
_____Constipation	_____Indigestion	

4. Family Health History:

Mother:

Father:

Brothers:

Sisters:

Other:

5. Do you smoke? ___yes ___no If yes, how much? _____

6. Do you enjoy physical activity? ___yes ___no Explain: _____
 Activity Level ___sedentary ___moderately active ___very active

If you participate in regular physical activity, please complete the table below:

List your activities	How many times a week do you do this activity?	How much time do you spend in this activity in a typical week?
1.		
2.		
3.		
4.		
5.		
6.		

7. List any food allergies or intolerances.

Drug History

List any prescribed, over-the-counter, herbal, or vitamin/mineral supplements you take.

Diet History

- Do you follow a special dietary plan, such as low cholesterol, kosher, or vegetarian? _____
- Have you ever followed a special diet? _____ Explain: _____
- Are there certain foods that you do not eat? _____
- Do you eat at regular times each day? ___yes___no How often? _____
- Identify any foods you particularly like. _____
- Do you drink alcohol? ___yes___no How often? _____
- What is your goal weight? _____

8. What is your lowest adult weight? _____ Age at this weight? _____

9. What was your highest adult weight? _____ Age at this weight? _____

10. Are you currently on a diet or taking prescribed or over-the-counter medication to lose weight or to maintain your current weight?

____ No

____ Yes, I am on a diet. Describe the diet.

____ Yes, I am on these medications:

11. If you have tried to lose weight in the past, please check all that apply

____ Diet(s) Describe.

____ Medications List

____ Other – Describe

Did you lose weight?

____ no ____yes If yes, _____ lbs over this period of time: _____

How much of this weight, if any, did you gain back? _____ lbs

What worked best for you and why?

12. What changes would you like to make?

Improve my eating habits____ Improve my activity level____
Learn to manage my weight____ Improve my cholesterol levels____
Other____

13. Please add any additional information you feel may be relevant to understanding your nutritional health.

14. Who prepares most of the meals in the home? _____ Shopping? _____

15. Do you use convenience foods daily? _____ yes _____ no

16. How often do you eat out? _____ Where? _____

Signature: _____ Date: _____