INFINITY PRIMARY CARE

New Patient Nutrition Assessment Form

Please complete the following questionnaire to the best of the your ability to give us an overall view of your general lifestyle and health habits.

General Information:

Name: _____ Date: _____

Who filled out this form? □ Self □ Other, please explain_____

Do you have any trouble hearing, seeing or reading ? □ No □ Yes Please explain _____

Do you follow any special diet or have diet restrictions or limitations for any reason?

_____

Who is your PCP? _____ Did anyone refer you today? If yes, who? _____

Goals and Readiness Assessment:

I would like to visit the dietitian, today because…

_____

_____

My food and nutrition-related goals are…

_____

_____

If I could change three things about my health and nutritional habits, they would be…

1. _____
2. _____
3. _____

My biggest challenge(s) to reaching my nutrition goals is/are… _____

On a scale of 1 (not willing) to 5 (very willing), please indicate your readiness/willingness to do the following:

To improve your health, how ready/willing are you to ...	**1**	**2**	**3**	**4**	**5**
Make changes to your diet					
Monitor dietary intake with practices like recordkeeping or measuring food					
Modify your lifestyle for your health					
Engage in regular exercise/physical activity					

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Physical Activity and Stress Information:

Do you exercise on a regular basis? □ No □ Yes If yes, please describe what type and how often…

_____

Is there anything limiting you from being more physically active? _____

_____

Is your doctor aware of the type and amount of exercise you do? □ No □ Yes

Indicate your daily stressors and rate the level of stress from 1 (extremely low) to 10 (extremely high)

□ Work _____ □ Family _____ □ Social _____ □ Financial _____ □ Health _____ □ Other _____

Do other people live at home with you? □ No □ Yes, how many and their relationship to you: _____

_____

Do you think those around you will be supportive of any healthy changes you make? □ No □ Yes If no, please explain_____

Weight History:

Height _____ What is your current weight _____ Desired Weight _____

Please describe your weight history_____

Intake Information:

In the past, I have tried the following techniques, diets, behaviors, etc. to reach my nutrition goals…

_____

Do you drink alcoholic beverages? □ No □ Yes, Please indicate what type and how often…

_____

Do you smoke? □ No □ Yes, Would you like information on quitting smoking? □ Yes □ No

Do you follow any special diet or have diet restrictions or limitations for any reason (health, cultural, religious or other)?

_____

Please list any food allergies, sensitivities or intolerances_____

_____

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Please write down everything you usually eat and drink in one day including snacks:

Meal	Time	What food and how much
Breakfast		
Snacks		
Lunch		
Snacks		
Dinner		
Snacks		

Eating Style: Based on how you eat on a regular basis, please check all that apply:

□ Fast Eater
□ Erratic Eater
□ Emotional Eater (stressed, bored, sad, etc.)
□ Late night-eater
□ Time constraints
□ Dislike "healthy" eating
□ Travel Frequently
□ Do not plan meals/menu
□ Rely on convenience items
□ Family members have different tastes
□ Love to eat
□ Eat too much
□ Eat because I have to
□ Negative relationship with food
□ Struggle with eating issues
□ Confused about food/nutrition
□ Frequently eat fast food
□ Poor snack choices

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Please indicate the frequency that you eat the following:

How often do you eat:	Never	2-3 X/mo	1 X/week	2-3 X/week	1 X/day	2-3X/day
Fast Food						
Restaurant Food						
Vending Machine Food						
Frozen Meals						
Red Meat (beef, pork, lamb etc.)						
Poultry (chicken, turkey etc.)						
Seafood (tuna, other fish, crab etc.)						
Dried Beans (pinto, black beans etc.)						
Baked goods (cookies, cakes, muffins etc.)						
100% Whole grain foods (oatmeal, whole grain bread etc.)						
Fruit (fresh, frozen, canned)						
Fats (butter, margarine, oil)						
Dairy (milk, yogurt, cheese etc.)						
Soy (soy milk, tofu etc.)						
Candy						

Please list all medications you take including over-the-counter medications and supplements:

Medication/Supplements	Dose	Schedule	Purpose

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Health History, please check illness or conditions that you currently have or have had:

□ Alcoholism/Drug Use

□ Arthritis

□ Breathing Problems

□ Circulation Problems

□ Eye Problems

□ Heart Problems

□ High Blood Fats/ Cholesterol

□ High Blood Sugar

□ Other

□ Kidney Problems

□ Liver Problems

□ Mental Health Problems

□ Numbness, tingling or burning in feet

□ Sleep apnea

□ Stomach Problems

□ Stroke

□ Thyroid Problems

I would like to learn more about:

□ Label Reading/Grocery Shopping

□ Dining Out

□ Cholesterol/Lipid Reduction

□ Increasing Fiber

□ Physical Activity

□ Diabetes Meal Planning

□ Diabetes Carb Counting

□ Weight Management

□ Balanced Eating

□ Healthy Grains

□ Increasing Fruits and Vegetables

□ Healthy Protein Choices

□ Healthy Fats

□ Meal Planning

Thank you for taking the time to fill out this Nutrition Assessment which will better help me address your needs and goals. I look forward to working with you.

Jill Gettle R.D.

Infinity Primary Care Wellness Center

248-533-0050