EASTERN MICHIGAN UNIVERSITY
OFFICE of NUTRITION SERVICES

Nutrition Assessment

Today's Date:_____

Basic Information

Name: _____Age:_____ Gender: _____ Date of Birth:_____

Phone Number:_____ Email Address:_____

I prefer to be contacted via (please circle): phone email

Reason for your visit:_____

Occupation:_____

Do you have children? Yes No Are you pregnant? Yes No Due Date_____

With whom do you live? (Include friends, roommates, children, parents, relatives)

_____

Health Information

Current Medical Conditions:_____

Past Medical Conditions: _____

Family Medical History: High Blood Pressure High Cholesterol Heart Disease Diabetes
Cancer Eating Disorder Food Allergies Other_____

Current Medications (include prescription and over-the-counter products):

_____

Current Vitamin/Supplements (vitamins/minerals, protein/amino acid supplements, herbal, diet pills):

_____

Please indicate how often you experience the following symptoms (circle):

Heartburn	Often	Sometimes	Rarely
Gas	Often	Sometimes	Rarely
Bloating	Often	Sometimes	Rarely
Stomach pain	Often	Sometimes	Rarely
Nausea/vomiting	Often	Sometimes	Rarely
Diarrhea	Often	Sometimes	Rarely
Constipation	Often	Sometimes	Rarely
Low energy	Often	Sometimes	Rarely
Loss/thinning of hair	Often	Sometimes	Rarely

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Lifestyle Information

Do you smoke/ use tobacco products? (circle) Often Sometimes Rarely Never

Do you drink alcohol? (circle) Often Sometimes Rarely Never

On average, how many hours of sleep do you get per night? Weekdays_____ Weekends_____

Do you currently exercise? Yes No

Is there any reason you cannot or should not exercise? _____

Activity	**Type/Intensity (low-moderate-high)**	**# Days per week**	**Duration per session (minutes)**
Cardio/Aerobics (walking, jogging, biking, swimming, elliptical trainer)			
Strength Training (weight lifting)			
Sports/Leisure			
Yoga/Stretching			
Other (specify/describe)			

Weight History

Would you like to be weighed today? Yes No

Current Weight: _____ Height: _____

For how long have you been at your current weight? _____

Have you had any recent changes in your weight that you are concerned about? Yes No

If yes, describe weight change and time frame:_____

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

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Nutrition History

Have you worked with a Dietitian or Nutritionist in the past? Yes No

If so, who, when, why:_____

Do you follow any special diet/nutritional program, check all that apply:

Low fat	Vegetarian	Weight loss	No dairy
Low carb	Vegan	Weight gain	Diabetic
High protein	Gluten Free	Low sodium	Other

If other please describe: _____

Do you have any food allergies, sensitivities, or intolerances? Yes No

Eating Patterns

Where do you eat most often? _____

How often do you eat out? _____

Who do you eat with? _____

Who cooks? _____ Who shops? _____

How often do you shop for groceries? _____

How many meals a day do you eat?_____ How many snacks a day do you eat?_____

Do you use any meal replacement products? If yes, what kind/how often?

Eating Style: **Related to how you eat on a regular basis, check all that apply:**

Fast eater	Poor snack choices
Slow eater	Do not plan meals/snacks
Emotional eater (sad, bored, stressed, etc.)	Time constraints
Late night eater	Dislike “healthy” food
Eat too little	Confused about food/nutrition
Eat too much	Picky eater

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Intake Pattern Please indicate how often you eat the following foods per day or per week

How often to you eat:	Per day, or	Per Week
Fruit		
Vegetables		
Breads, bagels, rice, pasta, cereal, other grains		
Dairy products (yogurt, cheese, milk)		
Red meat		
Poultry (chicken, turkey)		
Pork/ham		
Fish		
Plant-based protein (tofu, soy, beans, hummus, tempeh)		
Nuts/seeds (peanuts/peanut butter, almonds, cashews, sunflower seeds)		
Added fats/oils (salad dressing, cooking oils, butter, margarine, gravy)		
Sweet foods (ice cream, chocolate, cookies, cakes, candy)		
Snack foods (potato chips, pretzels, crackers)		

Please indicate how often you consume the following beverages per day or per week

Beverage Type	Daily Amount	Weekly Amount
Water		
Alternate dairy product Type:_____		
Juice □ natural □ fruit drink		
Soda □ regular □diet		
Coffee □reg. □ decaf □ latte		
Tea □reg. □ decaf		
Alcohol: □ wine □ beer □ liquor		

03/2012

Thank you! Please hand assessment form to ONS staff.

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For Office Use

Nutrition Assessment