Nutrition Assessment Form
Amy Tackett, MS, RDN

Name: _____ Date: _____

Age: _____ Gender: M F Phone: _____

Email: _____

Occupation: _____

Please list other people in your household and their relationships to you:

_____

_____

_____

Personal Health Status:

Height: _____Weight: _____

Your highest weight as an adult: _____

Your lowest weight as an adult: _____

What is your desired weight: _____

Have you recently gained or lost weight? (circle) Yes No

If Yes, Please explain how much and when: _____

_____

_____

_____

Diet History/Eating Habits:

List previous diets attempted with the year and outcome achieved:

_____

_____

_____

Do you currently restrict or avoid any foods, food groups or intake?

_____

_____

_____

Are you currently following a specific diet?

_____

_____

_____

Any food allergies or sensitive's?

_____

_____

_____

Amount of water consumed each day: _____

Amount of coffee, tea or caffeinated products consumed each day: _____

How often do you use tobacco? (circle)

Never Rarely (1-2 per month) Sometimes (1-2 per week)

Often (3+ per week) Daily (7+ per week)

How often do you drink alcohol?

Never Rarely (1-2 per month) Sometimes (1-2 per week)

Often (3+ per week) Daily (7+ per week)

How many meals and snacks do you eat per day? _____

How often do you eat out? _____

How often do you cook at home? _____

Have you seen an RD previously? If so, who? When? Why?

_____

_____

_____

Personal Medical History:

Are you currently being treated by another health care provider for any disease or health related issue? Please explain.

_____

_____

_____

Recent lab values available (i.e. glucose, A1C, sodium, potassium, etc):

_____

_____

_____

Any problems of diarrhea, constipation, heartburn, nausea or vomiting? _____

Current medications:

_____

_____

_____

Please list any psychological diagnosis (i.e. depression, anxiety or eating disorder):

_____

_____

_____

Please list any physical limitations or injuries:

_____

_____

_____

Are you on birth control or previously taken birth control? Explain.

_____

_____

_____

Any digestive difficulties? If yes, please describe.

_____

_____

_____

Lifestyle:

Do you participate in regular physical activity? (circle) Yes No

If so, please list activity type, duration and times completed per week:

_____

_____

_____

What is your stress level on a scale of 1 to 10? 1 being no stress and 10 being high stress

_____

Relaxation techniques practiced:

_____

_____

_____

Amount of sleep received on average each night: _____ hours

How do you rate your health? (Please circle one of the following):

Poor Fair Good Excellent

Family Medical History:

Circle any of the following a part of your family medical history:

High Blood Pressure High Cholesterol Diabetes Obesity

Heart Disease Cancer Thyroid Disease

Other (list):

_____

_____

_____

I desire to engage voluntarily in the YMCA's Nutrition Services with the YMCA's certified Registered Dietitian in order to attempt to improve my health and nutrition.

I acknowledge that the Registered Dietitian is not a physician and nutrition counseling is not a substitute for a diagnosis, treatment or care of disease by a medical provider. I am directed to contact my primary care physician to discuss any diseases, disorders or conditions.

I understand that the purpose of Nutrition Services is to improve, develop and maintain health through food and nutrition with specific dietary plans and recommendations. These activities can not be predicated with complete accuracy. I take full responsibility for the risks of any dietary changes.

I understand that I am responsible for monitoring my own condition and health through out the program and should any unusual symptoms occur, I will cease participation and inform the Registered Dietitian of symptoms.

I understand and agree to hold harmless the YMCA and its staff members for any and all claims, suites, losses, or related causes of action for damages, including but not limited to, such claims that may result from my injury or death, accidental or otherwise, during or arising in any way from the program.

In signing this consent form, I affirm that I have read this form in its entirety and that I understand the nature of the program. I affirm that my questions regarding the program have been answered to my satisfaction.

By signing, you verify that all information provided is accurate to your knowledge.
You understand that medical information sent through email is not HIPAA regulated and information may not inherently be secure. This process is for your benefit and intended only for the Registered Dietitian of YMCA's of Greater Dayton.

Client's Signature Date

_____ _____