NEW CLIENT ASSESSMENT FORM

Name: ☐ M ☐ F DOB:

Address:

Email Address: Phone:

ANTHROPOMETRICS:

Height: _____ Weight: _____ Goal Weight: _____

Body fat% _____ RMR: _____

Medical History:

☐ Heart Disease ☐ Diabetes

☐ High Chol/TG ☐ Cancer

☐ HTN ☐ GI (IBS)/other

HEALTH & FITNESS GOALS:

1.

2.

3.

Previous weight loss experiences, successes, failures, programs, etc?

Year Type Why did it not work out?

How many times per week do you eat out?

Days Restaurant Breakfast/lunch/dinner?

What would you identify as your biggest obstacles to achieving your goals?

Medications/Supplementation:

Type: For: Frequency Taken:

Food Allergies:

Food: Reaction You Had:

HEALTH & FITNESS HABITS:

Exercise/week

☐ Sedentary (No exercise)

☐ 1-2 x/week Type: Duration:

☐ 3-4 x/week Type: Duration:

☐ 5-6x/week Type: Duration:

Diet

Are you dieting? ☐ Yes ☐ No Number of meals you eat per day?

Caffeine

☐ None ☐ Coffee ☐ Tea ☐ Soda How much per day?

Alcohol

Do you drink alcohol? ☐ Yes ☐ No

If yes, how often?

How many drinks per week?

Tobacco Do you use tobacco? ☐ Yes ☐ No

WEIGHT RECORD/PROGRESS NOTES:

Date Weight

DIABETES/NUTRITION ASSESSMENT FORM

NAME: ___ ____ DATE: _____

HEALTH BELIEFS & ATTITUDES/ CULTURAL FACTORS (Please explain any "Yes")

Any concerns regarding your health? No / Yes: __Diabetes __Cholesterol __Weight __

Blood Pressure __Kidney
OTHER:_____

Any financial concerns affecting diabetes care? No / Yes:
_____

Any religious practices/restrictions affecting diabetes care? No / Yes:
_____

Any other information: _____

MEDICAL HISTORY You consider your health to be: [ ]Good [ ]Fair [ ]Poor

Do you take any medicines at home? No / Yes (Please list dose and # times taken)

_____ _____ _____

Do you take supplements: No / Yes:
_____

Do you smoke? [ ]No [ ]Yes (# packs per day:) Use alcohol? [ ]No [ ]Yes (# drinks per day____) or rarely

Health Care in past 12 Months # of Visits Reason Primary Doctor Hospitalization / ER Eye Doctor Foot Doctor Diabetes Education / Dietitian

EXERCISE OUTLINE

Do you exercise? No / Yes (If yes, you started, ____ days/months/years ago) # of minutes: ____/time How often? _____ times per week Any physical limitations? Yes / No (If yes, explain: _____) Type of exercise: ( )Walking ( )Bike ( )Physical Therapy ( )Gym Other cardio_____

PERSONAL BEHAVIOR GOALS:

My long term weight goal is to ( )decrease _____lbs or ( )increase _____lbs, or ( ) maintain weight 2-Other personal health goals of mine are to:

Make changes in my diet. To meet this goal I will _____ Increase my Physical activity. To meet this goal I will _____

BLOOD SUGAR MONITORING

MEDICATION:

STATUS [ ]Single [ ]Married [ ]Divorced [ ]Widowed Number people in household: ____ # Kids in household:_____ Primary emotional support person (circle one): self / spouse / parent / other _____ Any current major stresses? No / Yes (If yes, explain) _____

NUTRITIONAL SCREENING / CURRENT EATING HABITS Weight change in past 6 months? No / Yes: _____lbs (up / down) Following any diet? No / Yes Diet History:

You vary what you eat. Please mark/circle what you eat and drink on a

TYPICAL/USUAL DAY

BREAKFAST Time: LUNCH Time: DINNER Time: SNACKS Skips? Yes # days/week:_____ Out / Home / both

Drink:

Dessert:

Drink:

How often do you eat out? _Times daily / weekly / monthly

Do you currently have problem with? Chewing: Yes / No Swallowing: Yes / No

Lack of Appetite: Yes / No

3 or more Food Allergies: Yes / No Please explain any “Yes”: _____

DIABETES ASSESSMENT: If you do NOT have diabetes skip this section. ( ) I have Pre-diabetes How

long have you has diabetes? _____ days / months / years What type: ( )Type 1 ( )Type 2 ( ) Don't know What do you hope to learn about diabetes? [ ] diet [ ] blood sugar monitoring [ ] _____ Do you have any of the following problems (caused by diabetes)? Circle ones that apply:

Kidney Failure Heart Disease/Stroke Eye Problem Foot Problem Frequent Infections Sexual Problem Denial Depression High Blood Pressure Gastroparesis Anger Stress Other:

_____

Do you take diabetes medication?

Do you test your Blood sugar?

Do you have glucose over 200?

Do you have glucose below 70?

Do you test urine for ketones? YES / NO YES / NO YES / NO YES / NO YES / NO Which ones / How often How often?

Most recent fasting glucose:

2hrs post meals: _____

If yes: ( )Daily ( )Rarely ( )_____

If yes: ( )Daily ( )Rarely ( )_____

I certify that the above information supplied by me is true and complete to the best of my knowledge. The above information will be reassessed with each patient follow up visit. Changes will be noted on "Follow up sheet".

Patient Signature and Date:

_____