Medical Nutrition Therapy Assessment Form

Date: _____ Client #: _____
97802 / 97803 / Consult

Client: _____ Referral: _____

Male / Female Marital Status: S / M / D / W DOB: _____/_____/_____ Age: ____

Address: _____City: _____ State: ____ Zip: _____

Phone: (H) _____ (W) _____ (C) _____ Email: _____

Education: _____ Occupation: _____ Full-Time/Part-time/Unemployed/Retired

Insurance: _____ Member Number: _____

Physician(s): _____ Last physical/lab work? _____

Address: _____ Phone: _____

Reason for today's visit / What are your goals for the session(s)?

_____

Do you have or have you recently had… (check all that apply)

❑ Weight gain	❑ Weight loss	❑ Increased appetite
❑ decreased appetite	❑ Increased stress [L / M / H]	❑ Anxiety / ❑ Depression
❑ Fatigue	❑ Difficulty sleeping	❑ Nausea / ❑ Vomiting
❑ Diarrhea	❑ Constipation	❑ Indigestion / Belching
❑ Gas / Flatulence	❑ Other changes in bowel habits	❑ Dental problems
❑ Difficulty chewing	❑ Difficulty swallowing	❑ Excessive thirst
❑ Frequent urination	❑ Headaches	❑ Non-healing Wounds
❑ Shortness of Breath	❑ Chest pain	❑ Vision changes
❑ Numbness / ❑ Tingling	❑ Difficulty purchasing food	❑ Difficulty preparing food
❑ Tobacco use	❑ Other: _____	

Current Medications & Dosages	Current Dietary Supplements & Dosages

Height: _____ ft _____ in Weight: _____ lb BMI: _____

In the last 5 years, what was your highest weight? _____ lb lowest weight? _____ lb

Have you had problems controlling your weight? _____

Weight goal? _____ lb BMI: _____ Recent weight changes? _____

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PAST MEDICAL HISTORY: Have you, or members of your family, ever been told you have/had:

	You	Parent	Siblin
Heart Disease / Heart Attack			
Diabetes A1c:			
Gestational Diabetes			
High Blood Pressure			
High Blood Cholesterol			
High Triglycerides			
Stroke			
Cancer			
Liver Disease			
Gallbladder Disease / Gallbladder removed			
Kidney Disease Kidney Stones			
GERD / Reflux / Ulcer			
Thyroid Disease			
Polycystic Ovarian Syndrome (PCOS)			
Arthritis Gout			
Crohn's disease / Colitis / Irritable Bowel			
Diverticulosis / Diverticulitis			
Celiac Disease			
Osteopenia / Osteoporosis			
Allergies Food Allergies			
Asthma / Bronchitis / COPD			
Sleep disorder [CPAP - BiPAP]			
Headaches Migraine Trigger:			
Depression			
Anxiety Disorder			
Compulsive Eating / Over-eating			
Emotional Eating / Stress-eating			
Overweight / Obesity			
Other:			

❑ I don't know my family history

MEDICAL NUTRITION THERAPY ASSESSMENT FORM

DATE: _____ CLIENT #: _____

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FUNCTIONAL ASSESSMENT

READ EACH QUESTION CAREFULLY. COMPLETE OR FILL IN THE CIRCLE OF THE BEST ANSWER FROM THE CHOICES GIVEN. THEN GO TO THE QUESTION SPECIFIED AFTER YOUR RESPONSE. THANK YOU.

1. DO YOU HAVE ANY SERIOUS HEALTH PROBLEMS?

❑ YES ❑ NO

2. IN GENERAL, WOULD YOU SAY YOUR OVERALL HEALTH IS:

❑ EXCELLENT ❑ VERY GOOD ❑ GOOD ❑ FAIR ❑ POOR

3. HOW MANY NIGHTS PER WEEK DO YOU GET 7-8 HOURS OF SLEEP?

❑ SELDOM (<3X WEEK) ❑ OCCASIONALLY (3-4X WEEK) ❑ MOST (5-7X WEEK)

4. HOW MANY DAYS PER WEEK ARE YOU ABLE TO INCLUDE 45 MINUTES OF REGULAR PHYSICAL ACTIVITY?

❑ SELDOM (<3X WEEK) ❑ OCCASIONALLY (3-4X WEEK) ❑ MOST (5-7X WEEK)

5. HOW MUCH BODILY PAIN HAVE YOU HAD DURING THE PAST 4 WEEKS?

❑ NONE ❑ VERY MILD ❑ MILD ❑ MODERATE ❑ SEVERE ❑ VERY SEVERE

6. DURING THE PAST 4 WEEKS, HOW MUCH DIFFICULTY DID YOU HAVE DOING YOUR WORK OR OTHER REGULAR DAILY ACTIVITIES AS A RESULT OF YOUR PHYSICAL HEALTH?

❑ NONE AT ALL ❑ A LITTLE BIT ❑ SOME ❑ QUITE A BIT ❑ COULD NOT DO DAILY WORK

7. DURING THE PAST 4 WEEKS, TO WHAT EXTENT HAVE YOU ACCOMPLISHED LESS THAN YOU WOULD LIKE IN YOUR WORK OR OTHER DAILY ACTIVITIES AS A RESULT OF EMOTIONAL PROBLEMS (SUCH AS FEELING DEPRESSED OR ANXIOUS)?

❑ NONE AT ALL ❑ SLIGHTLY ❑ MODERATELY ❑ EXTREMELY

8. DURING THE PAST 4 WEEKS, TO WHAT EXTENT HAVE YOUR PHYSICAL HEALTH OR EMOTIONAL PROBLEMS INTERFERED WITH YOUR NORMAL SOCIAL ACTIVITIES WITH FAMILY, FRIENDS, NEIGHBORS, OR GROUPS?

❑ NONE AT ALL ❑ SLIGHTLY ❑ MODERATELY ❑ QUITE A BIT ❑ EXTREMELY

9. THESE QUESTIONS ARE ABOUT HOW YOU FEEL AND HOW THINGS HAVE BEEN WITH YOU DURING THE PAST 4 WEEKS. FOR EACH QUESTION, PLEASE GIVE THE ONE ANSWER THAT COMES CLOSEST TO THE WAY YOU HAVE BEEN FEELING. HOW MUCH OF THE TIME DURING THE PAST 4 WEEKS . . .

1= ALL THE TIME 3=A GOOD BIT OF THE TIME 5=A LITTLE OF THE TIME
2=MOST OF THE TIME 4=SOME OF THE TIME 6=NONE OF THE TIME

1 2 3 4 5 6 HAVE YOU FELT CALM AND PEACEFUL?
1 2 3 4 5 6 DID YOU HAVE A LOT OF ENERGY?
1 2 3 4 5 6 HAVE YOU FELT DOWNHEARTED AND BLUE?
1 2 3 4 5 6 HAVE YOU BEEN A HAPPY PERSON?

10. THE FOLLOWING ITEMS ARE ABOUT ACTIVITIES YOU MIGHT DO DURING A TYPICAL DAY. DOES YOUR HEALTH NOW LIMIT YOU IN THESE ACTIVITIES? IF SO, HOW MUCH?

1 = YES LIMITED A LOT 2 = YES LIMITED A LITTLE 3 = NO, NOT LIMITED AT ALL

1 2 3 LIFTING OR CARRYING GROCERIES
1 2 3 CLIMBING SEVERAL FLIGHTS OF STAIRS
1 2 3 WALKING SEVERAL BLOCKS

Please list all food & beverages, including the amounts consumed, for three (3) days. Please include all physical activity for these days.

	DAY 1	DAY 2	DAY 3
BREAKFAST			
SNACK			
LUNCH			
SNACK			
DINNER			
SNACK			
ACTIVITY			

Meals
Snacks

H_2O

R Soda
D Soda
Sw Tea
Unsw Tea

Vegetables
fresh
frozen
canned
juice

Fruit
fresh
frozen
canned
juice

Lean protein

Fats/Oils

WG

LF Dairy

Shops food

Reads FLs

Clnt Cooks/wk

Method

Other Cooks/wk

Meals out/wk
Restaurant
Fast Food
Buffet

Late eating

Mindless eating

Emotional eating

Stress eating

Other

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