lisha LOVES LIFE, LLC
WELLNESS NUTRITIONIST

INITIAL NUTRITION ASSESSMENT FORM

Name: _____ DOB/Age: _____ Gender: _____Email:_____

Reason for consultation: _____

Prior nutrition consultation? _____

Health & Medical History: Check all that Apply by filling in Box with C (current) or P (Past):

☐ Addiction (coffee/cigarettes/ sugar/ alcohol or other substances)	☐Eating Disorder: _____	☐ Memory concerns
☐ ADHD	☐ Fibromyalgia	☐ Menopause
☐ Food Allergies ☐Environ. ☐Seasonal	☐ Food allergies or Intolerances	☐ Neurological Disease: _____
☐ Anxiety / Depression / Mood swings	☐ GI Condition: _____	☐ Obesity ☐ Overweight
☐ Arthritis ☐ Osteo☐ Rheumatoid	☐ GERD, Heartburn, Hiatal Hernia	☐ Osteopenia ☐Osteoporosis
☐ Asthma	☐ Headaches	☐ Physical limitation: _____
☐ Autoimmune Condition: _____	☐ Heart condition	☐ PMS
☐ Pre-Diabetes ☐Diabetes	☐ High blood pressure /hypertension	☐ Prostate
☐ Cancer: Type _____	☐ High cholesterol	☐ Sexual dysfunction
☐ Celiac disease ☐Gluten intolerance	☐ IBD: ☐Crohn's ☐Ulcerative colitis	☐ _____
☐ Chronic fatigue syndrome/SEID	☐ Infertility	☐ _____
	☐ IBS: Type: _____	☐ _____

Family History:

Digestive function: ☐ Good ☐ Fair ☐ Poor
Bowel Movements : ☐ Daily ☐< 1x day ☐1-2x day ☐ Diarrhea ☐ Constipation

Signs & Symptoms (bloating, cramping, heart burn, etc.):

Rate your Typical energy level: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Lab & Diagnostic Data (List abnormal results or attach lab/blood work to this form/email):

Medications/Supplements (vitamins, Minerals, herbs, Medical foods, etc.)	Dosage	Frequency

ANTHROPOMETRICS

Height:	_____	Lowest adult weight:	_____	Waist: _____ Hip: _____ W/H: _____ BMI: _____ BAI:_____	
Current Weight:	_____	Highest adult weight:	_____	Does your weight affect the way you feel about yourself? _____	
Weight, 1 yr ago:	_____	Desired weight:	_____	Comments:	

LIFESTYLE

Exercise/ Activity: ☐ Yes Type: How often? How long?

☐ No Why not?

Sleep: ☐ 8+ hours ☐ 6-8 hours ☐ <6 hours Sleep Quality: ☐ Good ☐ Fair ☐ Poor

Life stressors:
☐ Work ☐ Family ☐ Finances ☐ Health ☐ Relationship/ friendships ☐ Other

What do you do to relax?

Comments:

DIET & FOOD HABITS

Do you follow a particular diet/eating pattern?
☐ No ☐ Yes
☐ Vegan ☐ Vegetarian ☐ Low carb ☐ Ketogenic ☐ Paleo ☐ Gluten Free ☐ Elimination Diet ☐ Other: _____
Comments:

What are your personal challenges to eating well?

Are you aware of any adverse food reactions (allergies/intolerances)?
☐ No ☐ Yes If yes, explain:

What percentage of meals do you eat out?
☐ 90-100% ☐ 75% ☐ 50% ☐ < 50% Where?

Do you grocery shop?
☐ Yes ☐ No If not, who does?

Do you cook?
☐ Yes ☐ No If not, who does?

3 DAY FOOD LOG

You may also use *MyFitnessPal (or other electronic food journals)* – scan and email as soon as they are completed. Include 2 weekdays and one weekend day. Be as specific as possible! Include measurements and brand names.
**Please do not change how you usually eat and include all food and beverages.*

Breakfast Time:	Lunch Time:	Dinner Time:	Snacks	Comments
Date (Day 1): Date (Day 2): Date (Day 3):				

ADDITIONAL COMMENTS

Include any information you would like me to know and goals you want to achieve!