

Outpatient Nutrition Assessment Form

Date: _____

Client Name: _____

Time: _____

Referring Clinician: _____

Site: _____

Precounseling Food Log Submitted

S Subjective Info

Reason(s) for Visit: _____

Goals: _____

Current Eating Pattern (*typical foods eaten, CHO, protein, fat, fruit/vegetables, restaurant food*)

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Beverages: _____

Allergies and Food Sensitivities: _____

Dietary Limitations (*dislikes, cultural/religious/ethnic preferences*): _____

Time/Prep Issues: _____

Sleep Patterns: _____

Stress/Environmental Issues: _____

Weight History: _____

Family Support: _____

(cont'd on next page)



Exercise Patterns (time, day, duration, type): _____

O Objective Info

Sex: _____ Age: _____ Height: _____ (inches) Current Weight: _____ (lb)

Peri/Post Menopause: _____

Med Hx: _____

Family Hx: _____

Medications, Supplements, OTC: _____

Labs

Glucose: _____ Albumin: _____ BUN: _____ Creatinine: _____

Sodium: _____ Potassium: _____ Cholesterol: _____ Triglycerides: _____

Hemoglobin: _____ Hematocrit: _____

Other: _____

A Assessment

BMI: _____ Target/Goal Weight: _____ Estimated Time to Reach Goal: _____

Estimated Nutrition Needs

_____ Total kcal _____ kcal/kg

_____ Protein (g) _____ % kcal _____ g/kg

_____ CHO (g) _____ % kcal

_____ Fat (g) _____ % kcal

_____ Fiber (g)

_____ Fe (mg)

_____ Ca (mg)

_____ Na max (mg)

_____ Fluid mL _____ cups _____ mL/kg

Additional Information: _____

Primary Dietary Issues: _____

(cont'd on next page)

P Plan

Foods/Ideas to Emphasize: _____

Foods to Limit: _____

Foods to Avoid: _____

Other Notes: _____

Handouts Given: _____

Rx to Achieve Goals: _____

Understanding, Motivation, Ability to Follow Recommendations: Good Fair Poor

Goals (*specific eating pattern, weight loss, clinical/biochemical parameters, etc*): _____

No Plan/Menu Meal Plan 1-Day Menu 3-Day Menu 7-Day Menu

Research Tasks: _____

Food Log for _____ Days Grocery Tour Location: _____ Date: _____

Follow-up Date and Topics: _____

Dietitian's Name (Print)

Dietitian's Signature

Date