Client Assessment Questionnaire

Demographic Data

Name: _____Date: _____

Address: _____ Home Telephone: _____

_____ Cell Telephone: _____

Email: _____

Sex: Male/Female Date of Birth: _____ Age: _____ Height: _____ Wt. _____

Health History

What medical concerns, if any, do you have at the present time?

_____

_____

Indicate if you have had blood relatives with any of the following problems: Please circle.

Cancer	High Blood Pressure	Diabetes	Osteoporosis
Heart Disease	Thyroid Disorder	High Cholesterol	

Do you have any complaints about any of the following? Please circle.

Appetite	Constipation	Menstrual Difficulties	Bleeding Gums
Diarrhea	Seeing in Dim Light	Bruising	Edema
Indigestion	Sudden weight change	Stress	Lethargy

Do you use tobacco in any way? Yes No

Did you recently stop smoking? Yes No

Do you enjoy physical activity? Yes No

Please list any food allergies or intolerances.

Drug History

Please list any prescribed, over-the-counter, herbal, or vitamin/mineral supplements you take.

Diet History

Do you follow a special dietary plan, such as, low cholesterol, kosher, vegetarian, vegan, etc.?

Have you ever followed a special diet? _____Explain: _____

Are there certain foods that you do not eat &/or do not like to eat? _____

Do you eat at regular times each day? _____ How often? _____

Identify foods that you particularly like? _____

Identify foods that are a comfort for you &/or a vice for you? _____

Do you drink alcohol? _____ How often? _____

What change would you like to make? _____

Improve my eating habits Improve my activity level

Learn to manage my weight Improve my cholesterol/triglyceride levels Other

Please add any additional information you feel may be relevant to understanding your nutritional health.

_____

In order to tailor your nutritional counseling experience to your needs, it would be useful to know your expectations. Please check one of the following to indicate the amount of structure you believe meets your needs:

Tell me exactly what to eat for all my meals and snacks. I want a detailed food plan.

I want a lot of structure, but freedom to select foods.

I want some structure and freedom to select foods.

I don't want a diet. I just want to eat better. I will set my own nutritional goals.

Brief Socioeconomic History

Are you employed? Full Time Part Time Occupation: _____

How many people in your household? _____ Pets? _____

Present marital status (select one):

Single Married Divorced Widowed Separated Engaged

Who prepares most of the meals in your home? _____

Who does most of the food shopping? _____

Do you use convenience foods daily? _____

How often do you eat out? _____ Where? _____

Have you made any food changes in your life you feel good about? Yes No

Who could support and encourage you to make dietary changes? _____

Educational Interests

What information would you like from your nutritional consultant? Please circle.

Supermarket Shopping Tour	Eating Out	Exercise
Weight Management	Portion Size	Alcohol Calories
Healthy Food Preparation	Eating Less Fat	Meal Planning
Fiber	Walking Program	Snack Foods
Food Labels	Other: _____	

Thank you for your willingness to share this information in an effort to make your nutritional consultation to best meet your needs. I look forward to working together with you to make lifestyle changes in order to meet your food and fitness goals!

Katherine A. Doll

Nutritional Consultant, AFPA

healthy options & you