

# Nutrition Assessment Form

Patient Information			
First Name	Last Name	Date of Birth	Gender
Email	Contact Number	ID	
Address	City	State	Zip Code
Anthropometric Assessment			
Weight	Usual Weight	Height	BMI
MUAC	Waist Circumference	Skinfold and Sites	
Other Measurements/Indices			
Notes			
Biochemical Assessment			
Lab Results			
Notes			
Clinical Assessment			
Pregnancy <input type="checkbox"/> Yes <input type="checkbox"/> No      Breastfeeding <input type="checkbox"/> Yes <input type="checkbox"/> No			
Smoker <input type="checkbox"/> Yes <input type="checkbox"/> No      If yes, how many pack-years			
Alcohol Consumption			
Activity Level <input type="checkbox"/> Sedentary <input type="checkbox"/> Moderately Active <input type="checkbox"/> Active <input type="checkbox"/> Very Active <input type="checkbox"/> Extremely Active			
Current Medication			
Pertinent Medical History			

**Patient Information**

First Name	Last Name	Date of Birth	Gender
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**Clinical Assessment (Continued)**

Allergies (Including Food Allergies)

Physical Findings

Notes

**Dietary Assessment**

**24-Hour Dietary Recall**

Time	Food or Drink	Quantity

Notes

Nutritionist Name	Nutritionist Signature	Date
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