CLIENT NUTRITION ASSESSMENT

Full name		Birthdate	
Food allergies			

Why are you seeking a weight loss program?	
What lifestyle changes will you need to make to have success in your weight loss journey?	
How do you see yourself benefiting from successful weight loss?	

DESCRIBE A TYPICAL 24-HOUR DAY OF FOOD INTAKE			
Breakfast		Mid-morning snack	
Lunch		Mid-afternoon snack	
Dinner		Bedtime snack	

AREAS THAT AFFECT YOUR WEIGHT		**If you answer YES – Please explain in space provided.**
Occupational (working around food / no time for lunch)	YES / NO	
Sleep	YES / NO	
Travel	YES / NO	
Household (family / obligations / schedule)	YES / NO	
Shopping or cooking	YES / NO	
Meals eaten away from home	YES / NO	

Additional Information:	

GROCERIES: I GET MY GROCERIES A THE: (PLEASE CHECK ALL THAT APPLY)			
Grocery store		Convenience store	
Farmers market		Other:	
How many times per month do you shop for groceries?			
What are the top 2 items you must have when you shop for groceries?			

DIET HISTORY: PLEASE ENTER INFORMATION ON WEIGHT LOSS PROGRAMS YOU HAVE ATTEMPTED PREVIOUSLY				
TYPES OF DIET PROGRAM OR WEIGHT LOSS METHODS	DATE INITIATED	DATE COMPLETE	WEIGHT LOST	WEIGHT REGAINED
Acupuncture				
Atkins diets				
Bariatric (gastric) surgery				
Diet pills – over-the-counter				
Diet pills - prescription				
Diet shots – HCG, B-12, diuretics				
Hypnosis				
Jenny Craig / L.A. Weight Loss / NutriSystem				
Keto / Paleo				
Mayo Clinic diet				
South Beach diet				
Trim Healthy Mama				
Weight loss program directed by a doctor				
Weight Watchers				
Whole 30				
Zone Diet				
Other:				
Other:				