Onk Nutrition & Wellness Solutions, LLC
Londonderry, NH 03053
(303) 517-5652

Initial Nutrition Assessment

Name: _____DOB:_____Age:_____Gender: M F Appointment Date: _____

Phone :(H) _____(W) _____(C) _____E-mail: _____

Referring MD: _____ Medical Dx: _____

Physician's phone, address, zip code_____

Marital Status: ___S___M___D___W___P Height: _____Weight:_____Desired Weight: _____

Occupation:_____Retired:_____Disabled:_____Other: _____

Primary Insurance Name: _____Type of Plan: (HMO, POS, PPO):_____

Subscriber Name: _____Relationship to you: _____Specialist co-pay:$_____

Subscriber ID #:_____Group ID #:_____Employer:_____

Please circle all of the medical conditions that apply to you:

Anemia	Diverticulitis/Diverticulosis	Irritable Bowel Syndrome
Anorexia	Food Allergies:_____	Kidney Disease: Stage_____
Arthritis	Food Intolerance:_____	Liver Disease
Binge Eating	Gallstones	Non-Celiac Gluten Sensitivity
Bulimia	Gastro-Esophageal Reflux (GERD)	Osteoporosis
Cancer:_____	Gout	Overweight/Obesity
Celiac Disease	Hemochromatosis	Pregnant/Lactating
High Cholesterol	Heart Disease	Thyroid Condition:_____
Constipation	High Blood Pressure	High Triglycerides
Crohn's Disease	Hyperglycemia (High Blood Sugar)	Ulcerative Colitis
Diabetes: Type_____	Hypoglycemia (Low Blood Sugar)	Ulcers
Diarrhea	Hemorrhoids	Underweight

Other Medical Conditions, Please Explain: _____

Current Medications (Dose & Frequency) _____

Pertinent Labs (A1C, Hg, serum albumin, vitamin/mineral levels, etc...)_____

How many meals do you eat each day? 1 2 3 4 5 6

What is the average size of each meal? Small Medium Large

Do you have Food Cravings? Salty Sugary Fast Food Meats Chocolate Cheeses Other: _____

How would you describe your appetite? Good Fair Poor Has your appetite changed recently? _____

Who does the cooking? _____Who does the grocery shopping? _____

How do you cook your food? (Circle all that apply) Oven Microwave Frying Pan Crock Pot Grill

How often do you eat out/take out? 1-2x week 3x week 4x week 5(+) times a week

Where do you eat out? _____

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24 hour Food Log:

Meal	Time	Ate/Drank
Breakfast		
Snack		
Lunch		
Snack		
Dinner		
Snack		
Other		

Do you ever skip meals? Which ones and why? _____

Do you ever feel your eating is out of control? Yes Sometimes Never If so, when? _____

Where do you eat most of your meals? Table Floor Watching TV Other: _____

Any Cultural, Ethnic or Religious food considerations? _____

What beverages do you drink on most days? (Include caffeinated beverages)? _____

Alcohol use? Yes_____ No_____ Frequency_____ Type_____

Do you currently smoke? _____packs/day Quit _____years/months ago Type: _____

How is your water intake? Poor Fair Good Excellent Estimated oz. of water a day? _____

What diet programs have you been on in the past year? Low-fat Low-cho High protein Jenny Craig

Weight Watchers Atkins The Zone Mediterranean Other: _____

Are you currently taking any vitamin or mineral supplements? _____

Activity Level: Inactive 1-2x week 3-4x week 5(+) x week How Long: _____

Activities you enjoy? _____

Do you have any physical limitations that limit the type of exercise you can do? _____

Current Nutrition Dx: _____

Nutrition Intervention/Education/Problem-solving: _____

Handouts Provided: _____

Monitor/Evaluation:

_____

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Patient SMART goals:

1.
2.
3.

What is your highest level of education? (Place a checkmark next to the appropriate answer)

____Grade School ____High School ____College ____Some College ____Advanced Degree

Are you interested in receiving e-mails from Onk Nutrition containing information about upcoming nutrition events and/or relevant health topics? _____Yes _____No thanks