



Nutrition Assessment

Name: _____ Appointment Date: _____

Phone number: _____ Email: _____

Gender (circle one): M or F Birth date: _____

Weight: _____ Height: _____

Would you like your weight to (circle one): Be lower Stay the same Be higher

What are your health and/or sport goals? _____

Your Personal Medical History (check all that apply):

Diabetes ____ Osteoporosis ____ High blood pressure ____

High Cholesterol ____ Heart Disease ____ Cancer ____

Kidney Disease ____ Liver Disease ____ Thyroid Disease ____

Anemia ____ Smoker ____ Fibromyalgia ____

Nausea ____ Vomiting ____ Acid Reflux ____

Diarrhea ____ Constipation ____ Ulcers ____

IBS ____ Diverticulitis ____ Crohns/IBD ____

PCOS ____ Chronic Fatigue ____

Pregnant ____ Number of months ____ Breastfeeding ____

Other (please list): _____

Family medical history (please list): _____

Your Personal Diet History (check all that apply):

Lactose intolerant ____ Vegetarian (ovo/lacto) ____

Please indicate if you are able to tolerate small amounts of the following: Vegan ____

following: Kosher ____

milk cheese yogurt

List all supplements and medications you are currently taking, as well as the amounts and the reason for taking them:

Supplement or Medication (Include brand name, if applicable)	Amount	Reason for taking

Have you followed any diets in the past? If so, please describe: _____

What are the barriers that have kept you from the diet you want to follow?

How many:	Per day	Per week	Per month
Times do you eat in fast food or sit-down restaurants . List the places you eat most often: _____ _____ _____			
Cups of milk or fortified soy drink do you have?			
Cups of juice do you drink?			
Cups of soft drinks do you drink?			
Cups of coffee or black tea do you drink? List anything you add to your coffee or tea and how much (e.g. 2 Tbsp cream and 2 Tbsp sugar).			
Drinks with alcohol do you have?			



Physical Activity

Describe the types of activities you participate in along with the frequency and duration of the activity.

Activity	Frequency of Activity (per week)	Duration of Activity (minutes)

Use the forms provided on the next pages to keep track of the food you eat for 3 to 5 days. Then bring the food record with you to your appointment or group session with the dietitian.

Try to be as honest as possible. Don't change your diet just because you are tracking it. This will let us give the most appropriate advice to help you achieve your goals.

Be sure to include as many details about:

- The times you eat at.
- What foods you eat. Include food and candies.
- The fluids you consume. Include water, coffee, tea, juice, pop, and no sugar added drinks.
- The amount of each food (e.g. cups, tablespoons, or ounces).

For example:

Time of Day	Food	Drinks
9:30 am	1½ cups corn flakes 1 scoop whey protein (gives 21 grams of protein) 1 white toast 1 tsp Becel margarine 1 Tbsp strawberry jam	1 cup of 2% milk 2 cups water

If you already use a computer or internet program to track your food, you may bring printed copies of that instead.

Date: _____

What time did you wake up at?

Time of Day	Food	Drinks

What time did you go to bed at?

Date: _____

What time did you wake up at?

Time of Day	Food	Drinks

What time did you go to bed at?

Date: _____

What time did you wake up at?

Time of Day	Food	Drinks

What time did you go to bed at?

Waiver and Acknowledgement

I, _____, hereby grant permission for Balance Nutrition Inc. and its employees, partners, volunteers, instructors, agents or representatives to correspond with my physician(s), coach and/or parent, other health care professionals, and employee assistance programs (hereby after known as EAP), or the Workers' Compensation Board (hereby after known as the WCB) to obtain information relevant to my nutrition treatment and counselling. I acknowledge that any information so obtained will be held in strict confidence.

If the nutrition services provided to you have been arranged and paid for as part of my insurance and/or treatment through the WCB or through an EAP, Balance Nutrition Inc. may be required to provide a written report to the WCB about the nutrition treatment and counselling I received from Balance Nutrition Inc.

I further acknowledge the information provided to me by Balance Nutrition Inc. is designed to meet my personal dietary needs. It is NOT suitable for any other individual and will not be transferred, copied or sold to another person.

In order to benefit from the treatment prescribed by Balance Nutrition Inc., I realize that it is important for me to inform either my physician or Balance Nutrition Inc. of any changes I make in the application of my diet. It is my responsibility to report any side effects or problems immediately and to make the necessary adjustments to my treatment plan with my physician and/ or Balance Nutrition Inc. I will not hold my physician or Balance Nutrition Inc. responsible for any complications that result from my failure to comply with either of the above.

I have agreed to have my Balance Nutrition Inc. keep records of our visits and to file these in a secure and appropriate place. I have agreed to have Balance Nutrition Inc. contact other health care professionals to benefit in my care and to share my personal information. This may be accomplished by letter, phone, fax, or email (per PIPA).

Date: _____

Client's Signature: _____

Witness(please print): _____

Witness Signature: _____