

Living Smart Diabetes

INITIAL NUTRITION ASSESSMENT

Age _____ Sex: ___M ___F Height _____ Current Weight _____ lbs

Desired Weight _____ lbs Physical activity level: ___light ___moderate/heavy BMI ___
 History: High Blood pressure Kidney disease high Triglycerides High cholesterol

1. Has your weight change in the past three months? p Yes p No Weight lost / gain _____ lbs

2. Which meals and snacks do you usually eat each day?
 ___Breakfast ___Lunch ___Supper ___Mid-morning snack
 ___mid-after snack ___evening/bed time snack ___during the night

3. Do you regularly skip meals? pYes pNo

4. Who does the grocery shopping? _____ Who does the cooking? _____

5. How is your food usually prepared? pFried pBaked pBroiled pGrilled

6. How often is your meal away from home?
 ___ Daily ___ 1 to 3 times per week or less ___ more than 3 times per week

7. What type of restaurant do you eat or carry out?
 pFast food pBuffet psit-down restaurant pother _____

8. Do you avoid eating any foods? pYes pNo Food Allergies: _____
 If yes, which ones?

9. Do you drink alcohol? pYes pNo
 If yes, what type (s)? pLiquor/spirits pwine pwine coolers pbeer
 How many serving do you usually take? p1 or more daily p2 to 5 weekly p rarely

10. If you and your dietitian discover changes you could make in your lifestyle to improve your health, would you be open to the changes? pYes pNo

If yes, who will support and encourage you? _____

11. Any other special diet needs?

Please tell us the foods you usually eat: You may write this on a separate piece of paper.

BREAKFAST/Time:	EDUCATOR TO COMPLETE THIS SIDE
	BEE: _____ Calories/day: _____ Carbs/day: _____
	%carbs _____ % protein _____ gms fat _____
Food Eaten/Amount/How Prepared	BREAKFAST
Comments:	Grams of Carbs: _____ Vegetables: _____
LUNCH/Time:	Meat: _____ Fat: _____
Food Eaten/Amount/How Prepared	LUNCH
Comments:	Grams of Carbs: _____ Vegetables: _____
DINNER/Time:	Meat: _____ Fat: _____
Food Eaten/Amount/How Prepared	DINNER
Comments:	Grams of Carbs: _____ Vegetables: _____
SNACK/Time(s):	Meat: _____ Fat: _____
Food Eaten/Amount/How Prepared	SNACK Grams of carbs : 15
Comments:	Dietitian/Educator: _____
	Review Date _____

Patient Name: _____ Signature _____ Date _____