DIETARY ASSESSMENT

Client Name ___________________________ Age ____________

1. Y N Do you eat/drink 2 – 3 servings milk, yogurt, or cheese every day?

2. Y N Do you eat 3 – 5 servings of vegetables every day?

3. Y N Do you eat 2 – 3 servings of meat, poultry, fish, dry beans, eggs, or nuts every day?

4. Y N Do you eat/drink 2 - 4 servings of fruit every day?

5. Y N Do you eat 6 – 11 servings of bread, cereal, rice, or pasta daily?

6. Y N Do you limit your fat intake? (use skim milk, low fat products, no fried foods, light deserts, etc.)

7. Y N Do you exercise 30 minutes- 3 times per week?

8. Y N Do you have difficulty obtaining, preparing, or storing food? (transportation, poor finances, inability to prepare foods) Explain ____________________________

9. Y N Do you have any dental problems that affect your ability to eat properly? Explain ____

10. When was your last dentist appointment? ________________________

11. Y N Do you drink soda pop? How much per day? ________________

12. How many glasses of water do you drink in a day? __________

13. Y N Do you consume caffeinated beverages? (coffee, tea, energy drinks, soda-pop) How much per day? ____

14. How many meals a day do you eat? _____ How many snacks per day? ________

What do you typically eat for snacks? ______________________________

15 How many times do you eat fast food and/or in a restaurant in a week's time? _____

16. Do you think that you are overweight or underweight? ______________________

Have you tried to do anything to improve this? _________________________

Plan for improving your nutritional/health status ____________________________
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Client Signature______________________________________ Nurse Signature ______________________
Date signed ___________________________

Revised 8/1/2016