

DIETARY ASSESSMENT

Client Name _____ Date of Birth _____

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? (uses 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 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 _____
When was your last dentist appointment? _____
10. Y N Do you have any medical condition/behavior or eating practices that may affect your nutritional health status? (Diabetes, pregnancy, breast feeding, tobacco/alcohol use, cultural/religious practices, special diets, eating disorders, food fads, eating patterns, nutritional supplements)?
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. How many meals a day do you eat? _____ How many snacks per day? _____
What do you typically eat for snacks? _____
14. How many times do you eat fast food in a week's time? _____
15. 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 _____

Client Signature _____ Nurse Signature _____
Date signed _____