

Nutrition Assessment Form

Patient Information				
First Name	Last Name	Date of Birth	Gender	
Email	Contact Number	ID		
Address	City	State	Zip Code	
Anthropometric Assessment				
Weight	Usual Weight	Height	BMI	
MUAC	Waist Circumference	Skinfold and Sites		
Other Measurements/Indices				
Notes				
Biochemical Assessment				
Lab Results				
Notes				
Clinical Assessment				
Pregnancy ☐ Yes ☐ No Breastfeeding ☐ Yes ☐ No				
Smoker ☐ Yes ☐ No If yes, how many pack-years				
Alcohol Consumption				
Activity Level ☐ Sedentary ☐ Moderately Active ☐ Active ☐ Very Active ☐ Extremely Active				
Current Medication				
Pertinent Medical History				

Patient Information			
First Name	Last Name	Date of Birth	Gender
Clinical Assessment (Continued)			
Allergies (Including Food Allergies)			
Physical Findings			
Notes			
Dietary Assessment			
24-Hour Dietary Recall			
Time	Food or Drink	Quantity	
Notes			
Nutritionist Name	Nutritionist Signature		Date