

**Jennifer Hanlin, MS, RD, MFT
Initial Nutrition Assessment**

Name:		Date
Phone:		Alt. Phone:
Address:		
Age	Ht	Wt

Weight History

Highest	Lowest	Ideal
Recent wt loss or gain:		
Programs:		

Medical History

Family Medical Issues:	
Own Medical Issues:	
Food Allergies	
Medications	Supplements
Digestive Problems	
Diet Aides	

**Lifestyle/Eating Behaviors
(Frequency)**

Exercise	Cooking done by
Eating out	Shopping done by
Fast food	Food fears
Convenience food	Motivation
Alcohol	Why now?
Sweets	
Favorite snacks	
Beverages	