Cornell Wellness Nutrition Assessment

Complete this form to the best of your ability and bring it with you to your nutrition consultation.

Name:_____DOB/Age:_____Gender:_____ Email:_____
Reason for consultation:_____
What do you hope to achieve in your nutrition consultation?_____
_____

Personal Health and Medical History: indicate all that apply with a C (current) or P (past)

	Addiction: Tobacco, Alcohol, Food		ADHD		Allergies Envir./Seasonal
	Arthritis: Osteo Rheumatoid		Asthma		Chronic Fatigue Syndrome
	Cancer: Type		Celiac/ Gluten Intolerance		Food allergies/intolerances
	Diabetes Pre-diabetes		Fibromyalgia		Headaches
	Eating disorder		GERD/Heartburn/Hiatal Hernia		High cholesterol
	GI Condition		High blood pressure		IBS
	Heart condition		Infertility		Osteoporosis Osteopenia
	IBD/Crohn's/Ulcerative Colitis		Obesity/Overweight		Prostate
	Menopause		PMS		Physical Limitations
	Other:		Other:		Other:

Medications/Supplements:

Medications, vitamins, herbs, probiotics, etc.	*Dosage/Frequency*

Physical Activity:
Type of activity/activities, how often, and how long:_____
_____
Energy:
On a scale of 1-10, what is your energy level most days (1 = poor, 10 = excellent)?_____
Sleep:
Duration most nights: ☐8hrs+ ☐6-8hrs ☐<6hrs Sleep quality most nights: ☐Good ☐Fair ☐Poor
Stress:
On a scale of 1-10, what is your stress level most days (1 = minimal, 10 = extreme)?_____
Life stressors: ☐Work ☐Family ☐Finances ☐Health ☐Relationships ☐Other_____
Digestion:
Bowel movements: ☐>2x/day ☐1-2x/day ☐<1x/day
Consistency: ☐hard/lumpy ☐smooth/soft ☐mushy/watery
Height/Weight:
Height:_____Current weight:_____Weight 1 year ago:_____
Lowest adult weight:_____Highest adult weight:_____Desired weight:_____

Diet/Food Habits:

Do you follow a specific diet or eating pattern?_____

What are your personal challenges to eating well?_____

Are you aware of any food intolerances or allergies? If so, what happens?_____

_____

Do you avoid any particular foods or beverages? If so, why? _____

_____

What is your average daily water consumption (8 oz glasses)? □ >8 □6-8 □4-6 □2-4 □<2

Do you grocery shop? □ Yes □ No If not, who does? _____

Do you cook? □ Yes □ No If not, who does? _____

What percentage of your meals are home cooked?_____

Typical Daily Intake:

Time	*Foods/Beverages Consumed*

What do you think would make the most difference in your overall health?

_____

_____

_____

_____

Please write a brief summary of any information that will be helpful to me regarding your health or medical history or in your own words, tell me your story.

_____

_____

_____

_____

_____

_____

_____

3 Day Food Record:
It would be helpful, but not required, if you could complete a food record prior to your appointment and bring it with you. Feel free to use the form below or an app of your choice like MyFitnessPal.

Instructions:
1. Record **everything** you eat and drink **for three days**. It is best to use two week days and one weekend day; record as soon after you eat as possible.
2. When describing a food, be specific and precise! Possible descriptors may include: brand name, cooked, raw, fresh, frozen, canned, chopped, whole, low fat, non fat, etc.
3. When recording amounts, use standard measures such as: cups, tablespoons, teaspoons, number of pieces.

Date	Time	Food/Description	Amount

Date	Time	Food/Description	Amount