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