Nutrition Appointment Pre-Assessment

To make an appointment, please call 716-645-2837 ext. 8 between the hours of 9:00 a.m. to 5:00 p.m.

Personal Information

Name

Phone (include area code)

Email (@buffalo)

Date of Birth (MM/DD/YYYY)

Gender

Height (feet, inches)

Weight (pounds)

Nutrition Assessment Information

1. What are your reasons for seeking a nutrition appointment?

2. Were you referred to a nutrition appointment? If so, by who?

3. Medical Diagnosis

4. Past Medical History (relevant to nutrition)

4b. [Females] Any previous or recent changes in menstrual cycle?

5. Family Medical History (any cardiovascular disease, diabetes, high blood pressure, high cholesterol, or eating disorders in family?)

6. Please list all medications (prescribed) you take

7. Please list all vitamins, minerals, herbs or other supplements (i.e., protein powders, etc.) that you take, and how often

8. Weight History – Please indicate your weight (lbs), since ~18 years or older

Weight (lbs)	Approx. Date	Comments
Lowest:		
Highest:		
Usual:		

9. Do you desire weight change?

10. Have you had any recent change in weight? Please describe.

11. Please list any previous diets or lifestyle changes you have done to change weight or improve health.

12. Any recent changes in your appetite? If so, please describe.

13. Food Allergies:

14. Food Intolerances (lactose, gluten, other):

15. Do you have any dietary restrictions or preferences (i.e. vegan, vegetarian, lactose intolerance, religious dietary observances, gluten sensitivity, etc.)?

16. List the foods you like in each of the following categories (OR indicate "*All Except*…")

Fruits and fruit juices

Vegetables, salads

Dairy products, dairy alternatives

Meat, poultry, fish, eggs

Beans (black beans, chickpeas, etc.), lentils, nuts, seeds, plant-based meats

Grains (breads, cereals, pasta, rice, etc.)

Desserts, snack foods

Beverages

Condiments, dressings, butter/margarine/oils

Are there any other foods you will not eat?

How much water do you drink daily, on average?

17. Please check any factors that you feel most affect your eating habits:

Stress

Boredom

Anger

Late night

Watching TV

Studying

Parties/holidays

Eating out

Snacking

Overeating

Become “starving”

Erratic schedule

Lack of availability/access to “healthy” food

Vending machines

Other

18. What is your biggest concern about your food intake or eating behavior?

19. Do you tend to eat the same foods from one day to the next?

20. Indicate your living situation:

On Campus – North

On Campus – South

Off Campus – by myself or with roommate(s)

Off Campus – with relatives

Other

21. Do you have a campus meal plan? If so, what type?

22. Do you do some food shopping?

23. Do you do some food preparation?

24. Is access to food or kitchen facilities a concern?

25. How physically active are you in a typical week?

Activities	Frequency	Duration

26. Do you smoke? If yes, how much daily or weekly (approx.)?

27. How many standard* alcoholic drinks might you consume in a typical week?

*12 oz beer; 1 shot; 5 oz wine

28. How would you rate your stress level on a scale of 1 to 10?

1 (very low) 10 (very high)

29. Do you feel you manage stress o.k.?

30. Hours of sleep you get each night, on average?

Less than 4

Greater than 4, but less than 7

7+

31. Have you had any previous nutrition counseling?

32. Have you had any nutrition classes at UB?

33. How many times do you typically eat per day (# meals, # snacks)?

34. Do you eat breakfast? Yes No SometimesTypical Breakfast:

35. Please show what a typical day of food intake looks like for you:

Time Food and drink (approx. volume or weight) **Activities Comments**

[e.g. 9 or 10amBagel & cream cheese or Clif bar; water (1 cup) on phone sometimes a banana]