ANNICK POIRIER

REGISTERED DIETICIAN

Nutrition Assessment

Name: ____________________

Date: ____________________

Phone Number: ____________________

Email: ____________________

Date of Birth: ____________________

Family Physician: ____________________

Ideal Weight: ____________________

Last Name: ____________________

Adress: ____________________

City: ____________________

Postal Code: ____________________

Height: ____________________

Age: ____________________

Present Weight: ____________________

How would you rate your overall health? Excellent Fair Poor

Have you ever been diagnosed with any of the following?

Diabetes High Blood Pressure High Cholesterol Sleep apnea Obesity Anorexia nervosa Bulimia Nervosia

Other: ____________________

Have you ever seen a dietitian before? If yes why: ____________________

Have you ever followed a diet before: ____________________

How ready are you to make a lifestyle change: Not ready 1 2 3 4 5 Ready

What are 1 or 2 things that you would like to change about your eating habits?

____

What motivates you the most to do a lifestyle change?

____

Do you skip meals? ____________________

How often do you eat? ____________________

How many coffees do you drink per day? ____________________

How many meals a day do you eat? ____________________

How often do you have a soft drink? ____________________

How many alcoholic beverages a day do you drink? ____________________

Medications: ____________________

Regular Physical Activity: ____________________

Supplements or vitamins: ____________________

Allergies or Food sensitivities: ____________________

DAILY FOOD INTAKE

Breakfast: ____________________

Lunch: ____________________

Dinner: ____________________

Snacks: ____________________

How did you hear about my services? ____________________

I authorize insurance companies to audit this form and all of its content ____________________

I understand this is a health service therefore under no circumstance any refunds are issued _______ initial