STEINER MEDICAL and THERAPEUTIC CENTER

Nutritional Evaluation

Please take a few moments to complete this nutritional evaluation. The completeness and honesty of your answers will help us best know how to assess your needs.

1. Dietary Intake Recall. List all foods and beverages which you have consumed in the last 24 hours. This includes meals, snacks, beverages, and condiments.

Name of Food	Preparation (baked, fried, boiled, etc.)	Amount (cups, tbsp,tsp,ounces)
ls this a typical day for yo	ou? Please explain if why not.	
Patient Name	Date	
2. Overall eating patter	ns:	
. How many meals and s	nacks do you eat each day?	
Meals	Snacks	
. How many times a wee	k do you eat the following meals away fro	m home?
Breakfast	Lunch	Dinner
What types of eating p	places do you frequently visit? (Check all	that apply)
Fast-food	Diner/cafeteria	
Restaurant	Other	
	pieces of fruit or glasses of juice do you	eat or drink each day?
Fresh fruit	Juice (8 oz cup)	

4. On average, how many se	rvings of vegetables do you e	eat each day?
-		-fiber breakfast cereal?
6. How many times a week do	,	
7. How many times a week d		· · · · · · · · · · · · · · · · · · ·
8. How many times a week d		
9. How many hours of televis	-	
•		·
	ile watching television? Yes _	
10. How many times a week		
11. What types of beverages day?	do you usually drink? How m	nany servings of each do you drink a
Water	Milk:	Alcohol:
Juice	Whole milk	Beer
Soda	2% milk	Wine
Diet soda	1% milk	Hard liquor
Sports drinks	Skim milk	
Iced tea		
Iced tea with sugar	_	
From The AAFP, Taking a Nutrition H 3. Are you currently on a s		
	•	
4. How would you describe Do you feel guilty about eati		d? (Do you have rigid rules about food? th food? Do you binge?)
5. What makes you choose	food that is unhealthy for y	you?

6. What makes you keep eating when you know you should stop?

7. What makes you avoid eating when you know you should eat?	
8. What are your goals for this visit?	