NUTRITIONAL ASSESSMENT

Name___________________________ Age____ Ht____ Weight_____ Pre-pregnant Wt._____ Wks Gest______

Keep a record of everything you eat and drink for 3 days. Choose days that you will be eating a diet that is typical, not unusual days such as Thanksgiving or days you will be on the road for most of the day. It is not necessary that the 3 days are consecutive. Please make a note of the serving size. A “steak” is not sufficient! For some a serving of steak is 6 oz., for others it is 18 oz!

DAY 1/Date	DAY 2/Date	DAY 3/Date
Breakfast	Breakfast	Breakfast
Lunch	Lunch	Lunch
Supper	Supper	Supper
Snacks	Snacks	Snacks
Water □ □ □ □ □ □ □ □ □ □ □ Coffee □ □ □ □ □ □ □ Sodas □ □ □ □ □ □ □ Tea (not herb) □ □ □ □ □ □	Water □ □ □ □ □ □ □ □ □ □ □ Coffee □ □ □ □ □ □ □ Sodas □ □ □ □ □ □ □ Tea (not herb) □ □ □ □ □ □	Water □ □ □ □ □ □ □ □ □ □ □ Coffee □ □ □ □ □ □ □ Sodas □ □ □ □ □ □ □ Tea (not herb) □ □ □ □ □ □

Are you currently enrolled in WIC? ☐ YES ☐ NO Food Stamps? ☐ YES ☐ NO

Do you have any special dietary needs or requirements of which you are aware? If so, what? ____________________
____ Are you currently breastfeeding? _________

Are there particular foods that you absolutely hate and will not eat? What ____________________________________
____

Are there particular foods (or other things) that you crave? What ____
____

Are you allergic to any foods? ______ If so, what type of reaction do you have? ________________________________

How many times do you eat MEAT _____ times per DAY WEEK MONTH ___ Never
How many times do you eat POULTRY _____ times per DAY WEEK MONTH ___ Never
How many times do you eat FISH _____ times per DAY WEEK MONTH ___ Never
How many times do you eat PORK (not cured) _____ times per DAY WEEK MONTH ___ Never
How many times do you eat BACON/HAM _____ times per DAY WEEK MONTH ___ Never
How many times do you eat EGGS _____ times per DAY WEEK MONTH ___ Never
How many times do you eat NUTS/SEEDS _____ times per DAY WEEK MONTH ___ Never
How many times do you eat BEANS _____ times per DAY WEEK MONTH ___ Never

Are the majority of the vegetables you eat daily: ☐ Fresh ☐ Frozen ☐ Canned
Are the majority of the fruits you eat daily: ☐ Fresh ☐ Frozen ☐ Canned
Which of the following do you have on a daily basis? ☐ Cottage Cheese ☐ Yogurt ☐ Hard Cheese ☐ Milk
Which of the following do you have on a weekly basis? ☐ Cottage Cheese ☐ Yogurt ☐ Hard Cheese ☐ Milk
Do you eat whole grain bread or white bread? ____________ Do you eat white rice or brown rice? ___________
Do you eat prepared breakfast cereals? If so, what ___________________________________ X per week? ______
Which of the following sweeteners do you use?
☐ Sugar ☐ Honey ☐ Aspartame (Equal, Nutrasweet) ☐ Sweet-N-Low ☐ Splenda ☐ Stevia ☐ None
Do you smoke? ______ How many cigarettes per day?______ Are you exposed to second-hand smoke? ________
How many times per week do you drink: Beer ______ Wine ______ Mixed Drinks or Hard Liquor _______

What supplements (vitamins, minerals, herbs, etc.) are you currently taking, including dose: _____________________
____
____
____
Is there anything else you think we need to know about your diet? ____
____
Do you believe you need to make any changes to your diet? _____ If so, what changes do you believe you should make? ____
____

--Do not write below this line--

Day 1 Nutritional Assessment Day 2 Nutritional Assessment Day 3 Nutritional Assessment

__________________________ __________________________ __________________________
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Recommendations: ____
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Reviewed by ____ Date ___________________