INTEGRATIVE AND FUNCTIONAL NUTRITION ACADEMY™

NUTRITION ASSESSMENT

Name: _____ DOB/Age: _____ Gender: _____Email:_____

Reason for consultation: _____

Prior nutrition consultation? _____

Health & Medical History: Check all that Apply by filling in Box with C (current) or P (Past):

☐ Addiction (coffee/cigarettes/ sugar/ alcohol or other substances)
☐ ADHD
☐ Food Allergies ☐Environ. ☐Seasonal
☐ Anxiety / Depression / Mood swings
☐ Arthritis ☐ Osteo
☐ Rheumatoid
☐ Asthma
☐ Autoimmune Condition: _____
☐ Pre-Diabetes ☐Diabetes
☐ Cancer: Type _____
☐ Celiac disease
☐Gluten intolerance
☐ Chronic fatigue syndrome/SEID
☐Eating Disorder: _____
☐ Fibromyalgia
☐ Food allergies or Intolerances
☐ GI Condition: _____
☐ GERD, Heartburn, Hiatal Hernia
☐ Headaches
☐ Heart condition
☐ High blood pressure / hypertension
☐ High cholesterol
☐ IBD: ☐Crohn's
☐Ulcerative colitis
☐ Infertility
☐ IBS: Type: _____
☐ Memory concerns ☐ MCI
☐ Menopause
☐ Neurological Disease: _____
☐ Obesity ☐ Overweight
☐ Osteopenia ☐Osteoporosis
☐ Physical limitation: _____
☐ PMS
☐ Prostate
☐ Sexual dysfunction
☐ _____
☐ _____
☐ _____

Family History:

Digestive function: ☐ Good ☐ Fair ☐ Poor Bowel Movements : ☐ Daily ☐< 1x day ☐1-2x day
☐ Diarrhea ☐ Constipation

Signs & Symptoms:

Rate your Typical energy level: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Lab & Diagnostic Data:

Medications/Supplements (vitamins, Minerals, herbs, Medical foods, etc.)	Dosage	Frequency

Medications/Supplements (vitamins, Minerals, herbs, Medical foods, etc.) continued	Dosage	Frequency

Height:	____	Lowest adult weight:	____	Waist: _____ Hip: _____ W/H: _____ BMI: _____ BAI:_____
Current Weight:	____	Highest adult weight:	____	Does your weight affect the way you feel about yourself?
Weight, 1 yr ago:	____	Desired weight:		Comments:

Exercise/Activity	☐ Yes	Type:	How often?	How long?
	☐ No	Why not?		
Sleep:	☐ 8+ hours ☐ 6-8 hours ☐ <6 hours Sleep Quality: ☐ Good ☐ Fair ☐ Poor			
Life stressors: ☐ Work ☐ Family ☐ Finances ☐ Health ☐ Relationship/ friendships ☐ Other				
What do you do to relax?				
Comments:				

DIET & FOOD HABITS:

Do you follow a particular diet/eating pattern?
☐ No ☐ Yes
☐ Vegan ☐ Vegetarian ☐ Low carb ☐ Ketogenic ☐ Paleo ☐ Gluten Free
☐ Elimination Diet ☐ Other: _____
Comments:

What are your personal challenges to eating well?

Are you aware of any adverse food reactions (allergies/intolerances)?
☐ No ☐ Yes If yes, explain:

What percentage of meals do you eat out?
☐ 90-100% ☐ 75% ☐ 50% ☐ < 50% Where?

Do you grocery shop?
☐ Yes ☐ No If not, who does?