

# Nutrition and Dietary Intake Assessment Form

Please complete this form as accurately as possible. This assessment will help design a personalized nutrition plan.

## 1. Patient / Client Information

Full Name:	<input type="text"/>		
Date of Birth:	<input type="text" value="DD/MM/YYYY"/>	Date of Assessment:	<input type="text" value="DD/MM/YYYY"/>
Phone Number:	<input type="text"/>	Email Address:	<input type="text"/>
Height (cm/in):	<input type="text"/>	Current Weight (kg/lbs):	<input type="text"/>
Target Weight:	<input type="text"/>	Occupation:	<input type="text"/>

## 2. Medical History & Dietary Goals

Primary Reason for Visit / Goals:	<input type="text"/>
Medical Conditions / Diagnoses:	<input type="text"/>
Current Medications / Supplements:	<input type="text"/>
Food Allergies / Intolerances:	<input type="text"/>
Food Dislikes / Avoidances:	<input type="text"/>

## 3. Typical Daily Dietary Intake

Describe your typical food and beverage intake for a normal day:

Meal / Time	Foods, Beverages, and Portion Sizes
<b>Breakfast</b> Time: <input type="text"/>	<input type="text"/>
<b>Mid-Morning Snack</b> Time: <input type="text"/>	<input type="text"/>
<b>Lunch</b> Time: <input type="text"/>	<input type="text"/>
<b>Mid-Afternoon Snack</b> Time: <input type="text"/>	<input type="text"/>
<b>Dinner</b> Time: <input type="text"/>	<input type="text"/>
<b>Evening Snack</b> Time: <input type="text"/>	<input type="text"/>

## 4. Lifestyle & Habit Assessment

Daily Water Intake (cups/liters):	<input type="text"/>
Caffeine Consumption (cups/day):	<input type="text"/>

Alcohol Consumption (drinks/week):

Physical Activity (Type, Frequency, Duration):

Average Hours of Sleep per Night:

Stress Level (Low, Medium, High):

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## 5. Clinician Notes & Recommendations (Official Use Only)

Assessment Notes:

Recommended Action Plan:

Client Signature:

Date:

DD/MM/YYYY

Clinician Signature:

Date:

DD/MM/YYYY