DiscoverPro
Inspire Wellness

CLIENT NUTRITION ASSESSMENT

Full name		D.O.B.	
Food allergies			

Why are you seeking a weight loss program?	
What lifestyle changes will you need to make to have success in your weight loss journey?	
How do you see yourself benefiting from successful weight loss?	

DESCRIBE A TYPICAL 24-HOUR DAY OF FOOD INTAKE

Breakfast		Mid-morning snack	
Lunch		Mid-afternoon snack	
Dinner		Bedtime snack	

ENVIRONMENTAL ISSUES THAT AFFECT YOUR WEIGHT

Occupational (working around food / no time for lunch)	YES		NO	
Sleep	YES		NO	
Travel	YES		NO	
Household (family / obligations / schedule)	YES		NO	
Shopping or cooking	YES		NO	
Meals eaten away from home	YES		NO	

If you checked yes on any of the above items, please explain.	

GROCERIES: I GET MY GROCERIES AT (PLEASE CHECK ALL THAT APPLY)			
Grocery store		Convenience store	
Farmers market		Other:	
How many times per month do you shop for groceries?			
What are the top 2 items you must have when you shop for groceries?			

DIET HISTORY: PLEASE ENTER INFORMATION ON WEIGHT LOSS PROGRAMS YOU HAVE ATTEMPTED PREVIOUSLY				
TYPES OF DIET PROGRAM OR WEIGHT LOSS METHODS	**DATE INITIATED**	**DATE COMPLETE**	**WEIGHT LOST**	**WEIGHT REGAINED**
Acupuncture				
Atkins diets				
Bariatric (gastric) surgery				
Diet pills – over-the-counter				
Diet pills - prescription				
Diet shots – HCG, B-12, diuretics				
Hypnosis				
Jenny Craig / L.A. Weight Loss / NutriSystem				
South Beach diet				
Weight program directed by a doctor				
Weight Watchers				
Other:				