NUTRITION ASSESSMENT FORM

Please fill out the following forms and bring them with you to your next appointment, or if you prefer email them to the office 24hrs in advance of your appointment. Email: admin@revivewellness.ca

Today's Date:	Insurance Provider (if applicable):
CLIENT INFORMATION	
Name:	Marital status: ☐Single ☐Married ☐Divorced ☐Widowed

Email Address:	Birth date:	Age:	Sex: ☐M ☐F

Which area best describes your neighbourhood:

☐ Beaumont	☐ Edm - Southeast	☐ Out of Edmonton
☐ Edm - Central	☐ Edm - Southwest	☐ Sherwood Park
☐ Edm – Millwoods	☐ Edm - West	☐ Spruce Grove
☐Edm – Northeast	☐ Leduc	☐ St Albert
☐Edm -Northwest	☐ Out of Alberta	☐ Stony Plain

Home number: (   )

Cell number: (   )

Work number: (   )

How did you hear/learn about Revive Wellness Inc (check all that apply):

☐ Blitz Conditioning	☐ Facebook	☐ Modern Mama	☐ Shepell
☐Convention/Health Fair	☐ Family/Friends	☐ Newspaper__________	☐ Target your Energy
☐ Corporate Presentation	☐ Live Local	☐ River Valley Health	☐ Television ___________
☐ Dietitians of Canada	☐ Local 4 Local	☐ Restaurant	☐ Trainer ______________
☐ Doctor ______________	☐ Magazine ____________	☐ Revive Wellness	☐ Twitter
☐ Edm Blog_____________	☐ Medicentre	☐ Search Engine	

Address: ___________________________ Apt. Number: __________ City: ______________________

Province: ___________________________ Postal Code: ________________

PERSONAL MEDICAL HISTORY		
Are you pregnant, breastfeeding or trying to get pregnant?	☐ Yes	☐ No
Do you have any food allergies or intolerances If yes, please describe which foods:	☐ Yes	☐ No

Medical history (check all that apply):

		☐ Attention Deficit Hyperactivity (ADHD)
☐ Heart attack and/or stroke	☐ High blood pressure	☐ High cholesterol
☐ Diabetes	☐ Cancer _________________	☐ Osteoporosis
☐ Menopause	☐ Polycystic ovarian syndrome	☐ Hypo/hyperthyroidism
☐ Kidney disease or Gout	☐ Liver disease	☐ Depression/anxiety
☐ Irritable bowel Syndrome (IBS)	☐ Inflammatory bowel disease (IBD)	☐ Sleep apnea

Are you currently taking any medications? If yes, please list:	☐ Yes	☐ No
Are you currently taking any supplements (including vitamins/minerals)? If yes, please list:	☐ Yes	☐ No

PERSONAL NUTRITION ASSESSMENT

What part of your eating habits do you feel you do well with already (describe or list 2):

For example: 1. I eat breakfast every day; 2. I have switched to decaf coffee for the last month

What part of your eating habits do you feel you struggle with? (describe or list 2):

For example: 1. Craving chocolate in the middle of the afternoon; 2. Mindless eating at night

What 2 nutrition goals do you want to work on with the dietitian? (describe or list 2):

For example: 1. Losing weight; 2. Menu planning and healthy recipes

Food Journal

Food records are a great way of determining how much you are eating, what types of food you are eating, and why you are eating

- Record everything that you eat for three days (include one weekend day and two week days)
- Include your fluid intake, for example water, juice, pop, milk or alcohol

Observe the following example:

Time of Day		Food/Beverage Description	Amount	Hunger Level
7:30am	Breakfast	Kellogg's Raisin Bran cereal	1/2 cup	Very hungry
		1% milk	1/2 cup	
		Sliced banana	Small (6")	
		Coffee with cream (approximately 2Tbsp) and sugar (2 cubes)	12 oz	
Time of Day	**Type of Workout Cardio (eg. biking), strength (eg. weights), stretching (eg. yoga), etc.**			**How Long?**
7pm	Power walked with friend			1hr

NOTE: Don't forget to include your activity (if applicable) at the bottom as shown above.

Food & Exercise Journal: (Date) ________________________

Time of Day		Food/Beverage Description	Amount	Hunger Level
	Breakfast			
	Snack			
	Lunch			
	Snack			
	Supper			
	Snack			

Time of Day	Type of Workout Cardio (eg. biking), strength (eg. weights), stretching (eg. yoga), etc.	How Long?

Food & Exercise Journal: (Date) ______________________

Time of Day		Food/Beverage Description	Amount	Hunger Level
	Breakfast			
	Snack			
	Lunch			
	Snack			
	Supper			
	Snack			

Time of Day	Type of Workout Cardio (eg. biking), strength (eg. weights), stretching (eg. yoga), etc.	How Long?

Food & Exercise Journal: (Date) ________________________

Time of Day		Food/Beverage Description	Amount	Hunger Level
	Breakfast			
	Snack			
	Lunch			
	Snack			
	Supper			
	Snack			

Time of Day	Type of Workout Cardio (eg. biking), strength (eg. weights), stretching (eg. yoga), etc.	How Long?