

Nutrition Specialists of New Jersey  
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### **New Client Nutrition Assessment Form**

**Client Information:**

Client Name: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_  
Gender (Circle One):     Male     Female  
Cell Phone #: \_\_\_\_\_  
E-Mail Address: \_\_\_\_\_

**Emergency Contact Information:**

Name: \_\_\_\_\_  
Relationship: \_\_\_\_\_  
Phone: \_\_\_\_\_

**Anthropometric Measures:**

Height: \_\_\_\_\_  
Current Weight: \_\_\_\_\_  
Desired Body Weight: \_\_\_\_\_  
Highest Adult Weight \_\_\_\_\_ When? \_\_\_\_\_ Weight 1 year ago \_\_\_\_\_  
Have you had any recent changes in your weight that you are concerned about?  
Yes \_\_\_\_ No \_\_\_\_

**Medical History:**

Current Disease Diagnosis (put N/A if not applicable) \_\_\_\_\_  
Current Medications: \_\_\_\_\_  
Approximate Amount of Hours of Sleep Per Night \_\_\_\_\_

**Current Activity Level** (Circle One)

Sedentary(no exercise)  
Moderately Active(3-5 times/week, 20-30 min. at a time)  
Active (3-5 times/week, 60 min. at a time)  
Very Active (3-5 times/week, 90. min at a time)  
Extremely Active (5+ times/week, 90 min. at a time)

**Does anything limit you from being physically active?**

\_\_\_\_\_

**Indicate daily stressors and rate the level of stress from 1 (extremely low) to 10 (extremely high):**

Work \_\_\_\_\_ Family \_\_\_\_\_ Social \_\_\_\_\_ Financial \_\_\_\_\_ Health \_\_\_\_\_

**Special Diets:** (Ex: Vegetarian, Vegan, Kosher) \_\_\_\_\_

**Food Allergies:** \_\_\_\_\_

**Behaviors (If applicable, indicate approx. how many per day):**

Smoking \_\_\_\_\_

Alcohol Use \_\_\_\_\_

Water (approx. cups/day) \_\_\_\_\_

How would you rate your overall health from 1-10? \_\_\_\_\_

Who prepares the majority of your meals? \_\_\_\_\_

Who shops for food? \_\_\_\_\_

**I would like to visit with the dietitian, today because...**

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**My food and nutrition-related goals are...**

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**The biggest challenge(s) to reaching my nutrition goals is/are:**

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**In the past, I have tried the following techniques, diets, behaviors, etc. to reach my nutrition goals...**

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## For Nutritionist Use Only:

Breakfast (Include Beverages)	Lunch (Include Beverages)	Dinner (Include Beverages)	Snacks (Include Beverages)

Ideal Body Weight:

BMI:

Energy Needs:

Protein Needs:

CHO Needs: