NUTRITIONAL ASSESSMENT

NAME:_____ DATE:_____

1. **Do you have any food allergies? ____yes ____no**
2. **List your food allergies._____**
3. **List the foods you dislike._____**
4. **List the foods you have problems with and what types of problems you have. _____**
5. **How many meals do you eat daily? _____**
   How many of these meals do you eat alone? _____
6. **Do you feel like you eat a well balanced meal at least once a day? _____**
7. **List the number of protein foods you eat each day such as meat, eggs, beans._____**
8. **List the number of servings of vegetables you have daily. _____**
9. **List the number of servings of fruit or fruit juice you have daily. _____**
10. **How many 8 oz. cups of water do you drink daily? _____**
11. **How many cups of tea, or coffee do you drink a day? _____**
12. **Do you drink alcoholic beverages? _____How often?_____**
13. **Do you sometimes forget to eat or drink? _____**
14. **Do you have your own teeth? _____**
15. **Do you have dentures or a partial plate? _____Describe_____**
    _____
16. **Do you have difficulty chewing or swallowing? _____**
17. **What help is provided at meal time for you? (example: meat is chopped) _____**
18. **Have you lost or gained more than 6 pounds in the last 6 months?_____**
    Describe_____
19. **What is your current weight? _____**
20. **How tall are you? _____**
21. **Do you walk regularly? _____ About how many minutes of walking do you do a day? (around the home can be counted)_____**
22. **Do you have difficulty with constipation? _____If yes, how do you treat it?_____**
23. **Do you have any pressure ulcers or opened areas on your skin? _____**
    Describle_____