Assessment Form

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DATE: ……………………

NAME:……………………………………………………………………………..

DATE OF BIRTH: -…………………….. HEIGHT:………………… WEIGHT:……………………

MARRIED/UNMARRIED…………………….. MALE/FEMALE………………………………

ETHNICITY :(RELIGION-FOR DIETRY PREFRENCE ONLY)………………………………

LANGUAGE SPOKEN AT HOME:……………………

MEMBERS IN FAMILY ……………

VEG/ NON VEG/EGGETARIAN: …………….

PROFESSION:……………………………..

WORKING-YES/NO………

IF YES TIMINGS AND TYPE OF WORK……………………

MOBILE NO (1)…………………………….(2)……………………..LANDLINE…………………..

EMAIL ID:……………………………………………………………………………………………

RESIDENTIAL ADDRESS (COMPLETE)…………………………………………………………….
……

CLIENT HISTORY

DIABETES- YES/NO……..
IF YES: TYPE 1…………….TYPE 2………………… SINCE HOW MANY YEARS…………………?
NAME OF MEDICATIONS: ....
LAST READING…………………………………RANDOM/PP/FASTING (PLEASE TICK)

BLOOD PRESSURE-YES………….NO………….(PLEASE TICK)
IF YES:
HIGH/LOW……………………… LAST READING (DATED)…………………………………
NAME OF MEDICATIONS:………………………………………………………………………
……………………………………………………………………………………………………….

THYROID: YES/NO
IF YES: HYPOTHYROID………………………… HYPERTHYROID:………………………..
NAME OF MEDICATIONS CONSUMED……………………………………………………

THALESSEMIA: YES/NO……………. MAJOR/MINOR………………………………….

CHOLESTEROL: - YES/NO (IF YES PLEASE ATTACH LATEST REPORTS)………………..

SMOKING: YES/ NO ………..IF YES HOW MANY CIGARETTES PER DAY…………….

ALCOHOL YES/NO……………. TYPE &QUANTITY……………………………………………..

PAAN/TOBACCO:………………………… YES/NO…………………………..(PLEASE SPECIFY)

OTHER ISSUES (PLEASE ENCIRCLE THE BELOW)

ASTHMA/ANEMIA/CONSTIPATION/GOUT/STONES (SPECIFY TYPE)/FLATULENCE (GAS)/PCOD/DEPRESSION/ACIDITY

OTHERS……………………………………………………………………………………….

ANY PAST HOSPITALIZATION OR SURGERY: YES/NO…………………………..

IF YES (SPECIFY DATE &REASON)…………………………………………………………

FOOD ALLERGIES: YES/NO………… IF YES WHICH FOODS…………………………..?

LACTOSE/GLUTEN INTOLERANT/NONE/ ……………………………………………......

DIET PLAN REQUIRED FOR

WEIGHT LOSS/ WEIGHT GAIN/ WEIGHT MAINTAINANCE/DISEASE SPECIFIC/GYM (PLEASE TICK THE MOST PREFERED ONE)

ANY OTHER (PLEASE SPECIFY)…………………………………………………………………………………….

PHYSICAL ACTIVITY: - YES/NO……………..

IF YES (SPECIFY THE TYPE AND DURATION OF ACTIVITY)………………..........................
………..
………..
………..

NAME AND TIMINGS OF DIETRY SUPPLEMENTS or MEDICATIONS (IF CONSUMED)

1)……………………….. 2)……………………3)……………………..4)………………………5)………………
6)………………………..7)……………………8)……………………..9)……………………….10)…………….

DIETRY RECALL (TIMINGS COMPULSORY)
Be as specific as possible

EARLY MORNING……………………………………………………………………………………………..

BREAKFAST……
……’

MID MORNING…………………………………………………………………………………………………

LUNCH :…………………………………………………………………………….................................
……

EVENING SNACKS:……………………………………………………………………………………………

DINNER:……….
……..

(PLEASE SPECIFIY THE PORTION SIZE i.e. no of chappatis, size of katchori (small or big)
EATING OUT (PLEASE SPECIFY TYPE OF FOODS CONSUMED AND HOW MANY TIMES A WEEK)
……..
………..

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DISCLAMER:

1) The above information must be true to the best knowledge of the provider.

2) The above assessment form/data shall not be replicated without the information of the medical professional. Anyone doing so shall be punishable under law & liable for legal action.

3) The above information provided would be strictly confidential and not be shared with Anyone.

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DIETICIAN & LIFESTYLE CONSULTANT

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