NUTRITIONAL ASSESSMENT
DR. THOMAS M. WALSH II

Today 's Date: _____

Name: _____ **Date of Birth:** _____ **Age:** _____

Physical Status:

Have you recently lost or gained weight? YES/NO _____ LBS.

Height : _____
Weight: _____
Pulse: _____
B.P.: _____

Lifestyle:

Exercise YES/NO IF yes, how often? _____ **Type:** _____

Other Physical Activities: _____

Tobacco Use : _____ **Alcohol Use :** _____
Woman:
Regular Menstrual Cycles: YES/NO
Age of first period: _____

Diet :

Vitamin/Mineral Supplements Use : _____

Food Allergies: _____

Food Dislikes: _____

Describe your daily eating habits:

How often do you eat at restaurants, take-out or fast food?

DIETARY INTAKE: **Name:** _____

FOOD GROUPS:	**# Daily Servings**	**# Weekly Servings**
Breads, cereal, pasta, rice, other grains:		
Fruits:		
Vegetables:		
Milk, Cheese, Yogurt :		
Meat, Fish, Poultry, Eggs :		
Lentils, Beans, Tofu:		
Peanut Butter, Nuts:		
Fats, such as Margarine, Mayonnaise, Sour Cream:		
Oils:		
Fried Foods/Salty Snacks:		
Desserts:		

PRODUCTS:	**Daily Servings**	**Weekly Servings**
Sweet beverages:		
100% Fruit Juice:		
Alcohol:		
Water:		
Caffeine Beverages/Energy Drinks:		
Sports Drinks/Bars:		
Chewing Gum:		