Medical Nutrition Therapy Assessment for Weight Management
Duke Primary Care

Name _____ D.O.B _____ Gender _____

WEIGHT HISTORY

Current Weight: _____ Lowest Adult Weight: _____

Highest Adult Weight: _____ Recent Weight Change: _____

Successful weight loss techniques attempted _____

Unsuccessful weight loss techniques attempted _____

NUTRITION PROBLEMS

Food Allergies: _____ Food Intolerances: _____

Prior Diet/Restrictions**:** _____

NUTRITION

Do you cook your meals? ☐Yes ☐No Do you go grocery shopping? ☐Yes ☐No

How many meals do you eat each day? _____ Snacks: _____

Do you take any nutritional drinks or bars? _____

Do you miss meals: ☐Yes ☐No How often? _____

On average, how many servings of the food groups below do you eat daily? (please answer each separately)

Fruit_____ Non-starchy Vegetables_____ Milk/Yogurt _____

What do you drink during the day? _____

How many meals a week do you eat out? _____

How do you prepare you foods? (Circle All that Apply):

Deep Fry Bake Grill Roast Stir Fry Air Fry Boiled

Please List your usual eating times, foods, and beverages:

Time: ____ Meal 1: _____

Time: ____ Snack: _____

Time: ____ Meal 2: _____

Time: ____ Snack: _____

Time: ____ Meal 3: _____

Time: ____ Snack: _____

PHYSICAL ACTIVITY

Do you exercise ☐Yes ☐No Type of exercise_____

How many minutes? _____ on how many days per week?_____