Name:_____
Birth Date:_____ Today's Date:_____

Medical Nutrition Therapy Assessment
For Adolescents
Ages 13-17 years old

Please help us provide better care to you by answering all questions to the best of your ability. This information will help the dietitian develop your nutrition treatment plan.

If you were referred to this appointment, who referred you (doctor, therapist, etc.)?
_____
Do you see any specialty providers (allergist, gastroenterologist, etc.)? If so, please list what types:
_____
Please share how you are hoping to benefit from meeting today and/or any nutrition concerns that you have (including concerns about your eating habits):
_____
_____
_____
Have you worked with a Registered Dietitian in the past? ____Yes ____No
If yes, was it helpful? Why or why not?
_____
_____
_____
Do you have any concerns with your current weight, body image, or body shape?
____Yes ____No If yes, what are your concerns?_____
_____

Are you on a special diet? ___Yes ____No
If yes, what?_____

Is anybody you live with or that is in your family on a special diet: ___Yes __No
If yes, what?_____

Weight Loss/Gain
Do you currently weigh yourself? ____Yes ____No If yes, how frequently? _____

How tall are you?_____
How much do you weigh? _____

Describe your growth pattern as a child (underweight, overweight, normal development):

_____

_____

_____

Do you have a weight that you want to be? _____lbs

Have you ever been at this weight previously? ___Yes ___No If so, what was your age?_____

Any recent weight changes? ____Yes ____No

If yes, please describe:

_____

_____

Health History

Please check any health concerns, add in any additional pertinent information.

Lung or Breathing Problems:

- ☐ Asthma
- ☐ Bronchitis
- ☐ Other_____

Cardiovascular:

- ☐ High cholesterol
- ☐ High blood pressure

Endocrine:

- ☐ Thyroid problems
- ☐ Diabetes

Autoimmune:

- ☐ Celiac Disease
- ☐ Lupus

Other:

- ☐ Anemia
- ☐ Liver disease
- ☐ Kidney disease
- ☐ Substance abuse
- ☐ Difficulty chewing
- ☐ Difficulty swallowing
- ☐ Fetal Alcohol Spectrum Disorder
- ☐ For females, age of first menses:_____
- ☐ Any missed cycles?

Gastrointestinal:

- ☐ Abdominal pain
- ☐ Cramping
- ☐ Gas
- ☐ Bloating
- ☐ Constipation
- ☐ Diarrhea
- ☐ Non-celiac gluten sensitivity
- ☐ IBS
- ☐ Crohn's Disease
- ☐ GERD

Neurological:

- ☐ Seizures
- ☐ Numbness/tingling in hands or feet
- ☐ Dizziness
- ☐ Trouble concentrating

Skin:

- ☐ Dermatitis herpetiformis
- ☐ Other:_____

Mental Health Diagnosis:

- ☐ Autism Spectrum Disorder
- ☐ ADHD/ADD
- ☐ _____
- ☐ _____

Allergies/Intolerances

What allergies, sensitivities, and intolerances (to drugs, food, latex, environmental) or adverse reactions have you experienced?

Allergic or intolerant to:	**Reaction time: (eg-immediate, slow, etc.)**	**Type of reaction or problem:**

Do you drink cow's milk and/or eat dairy products? ___Yes ___No
If no, why not?_____

Have you previously been tested for any food allergies or sensitivities? ____Yes ____No
If yes, please explain:
_____
_____
_____

Sleeping Patterns

What time do you usually wake up?_____
What time do you usually go to bed?_____
Average hours of sleep per night? _____

Do you ever get hungry before you go to bed or in the middle of the night? ___Yes ___No
If yes, describe_____

Any comments or history regarding your sleeping patterns (ex: sleep studies, current medications or supplements, etc.):

_____

Exercise Patterns and Attitudes

Are you involved in any sports? ___Yes ___No
If yes, what do you do? How often do you practice and for how long?_____
_____
_____
_____
_____

Do you do any other types of activity or exercise?_____

How many hours a day do you spend watching television or playing video games? Is it more or less hours on the weekends? Please describe:

Have you ever been told to stop doing exercise or activity? ___Yes ___No
If yes, why?

_____

Medications and Supplements

List all medications you are currently taking.

- ☐ I am not currently taking any medications

Medication	Reason for Use	Negative side effects experienced

List all supplements you are currently taking.

- ☐ I am not currently taking any supplements

Supplement	Reason for use	Dose and times per day

Eating Patterns

Where do you attend school? _____

What meals or snacks are provided at school? _____
_____
_____

Within your household, who does most of the cooking?_____
Within your household, who does most of the grocery shopping?_____
Do you eat family meals? ___Yes ___No
Please describe meal time: Who portions the food?

Are you a picky eater? ___Yes ___No
If yes, please describe: _____
_____
_____

Any feeding issues currently or as a child? ___Yes ___No
If yes, please describe:_____
_____
_____

Any texture issues with food? ___Yes ___No
If yes, please describe:_____
_____
_____

How many times per week do you eat at restaurants or get take out? _____
Where do you go? What do you like to order?
_____
_____
_____
_____

Do you have a concern with any of the following (check all that apply)?

☐ Binge Eating	☐ Purging	☐ Restrictive eating	☐ Overeating
☐ Night Eating	☐ Body Image	☐ Excessive exercise	☐ Other_____

Do you drink soda, coffee, or energy drinks? ___Yes ___No
If yes, what kinds and how much?_____
_____

Diet Recall: As best as you can recall, please write down your food and beverage intake from yesterday (include meals, snacks, beverages, portions, and times)

Would you consider this a typical day? ____Yes ____No If no, why not?

_____

_____

Motivation

On a scale of 1-10, (10=extremely motivated; 1= no motivation at all), how would you rate your current motivation to make nutrition and lifestyle changes?_____

What might make it hard to make changes?

_____

_____

_____

Who are the support people in your life?

_____

_____