

GRAND VALLEY STATE UNIVERSITY
RECREATION

Nutrition Intake

Name: _____

Date: ____/____/____

D.O.B/ Age: _____

Male/Female/Other: _____

Student/Staff: _____

Referred by: Counseling Center

Women's Center

Therapist/PCP

Fitness & Wellness staff

Athletic Department

Other (please specify) _____

Reason for referral: _____

What are you hoping to achieve from your session? _____

Height: _____ Weight: _____ Desired Weight: _____

Recent weight change/time frame: _____

Do you follow a special diet? _____

Food Allergies/Food Intolerance/Sensitivities: _____

Constipation _____ Diarrhea _____ Nausea _____ Bloating _____

Current Living Situation: _____ Meal Program: Yes/No _____ Meals/Week: _____

How often do you eat on campus? What campus dining restaurants do you eat at most frequently? _____

How often do you eat out at restaurants off campus? Note frequency and restaurants you eat at most often, including take out and fast food: _____

Typical Day of Food and Beverage Intake: Please note quantities and time of day.

Meal	Time	Food and Drink eaten (Describe, be Specific)
Breakfast		
Lunch		
Dinner		
Snacks		

Note amounts/frequency of commonly consumed beverages; juice/soda/coffee/tea/alcohol: _____

How often do you cook? Do you enjoy cooking? Do you feel confident with your cooking ability? _____

Nutrition Assessment: to be completed by staff

Client's readiness for change: _____

Recommendations & Care Plan:

Referral to: _____

Nutrition education provided: _____

Food journals to enhance awareness of eating behavior

Continue nutrition education on: _____

Client could improve eating patterns by: _____

Recommended follow-up session? X1 X2 Date scheduled: _____

Provided RD email for questions

Recommended Resources: _____

Client Established Goals:

1. _____

2. _____

3. _____

4. _____

Topics to Review at next Appointment: _____

Date: _____ Signature, RD: _____