Nutrition assessment

Date:

Name: Gender: DOB: Ph:

(If a child/adolescent – name and contact details of parents):

Address:

GP: (name/contact details)

Referrer: (date/contact details)

Others in treatment team:

Reason for referral/presenting to treatment:

Medical and mental health history:

(including previous treatment for an eating disorder, and/or hx of suicidality or self-harm behaviours).

Are there any current mental health risks?

Medications:

(including contraception use, supplements (such as vitamin/mineral/protein)).

Substance use history:
(including cigarettes, alcohol, other substances and amount/frequency).

Social situation:
(work/study/living situation).

Social supports:
(including friends, family, colleagues, teachers)

History of ED behaviours:
(including time-frames of behaviours):

Include open questions in regards to:

- The client's experience or views of their eating/weight/shape concerns over time to the current presentation and what may be maintaining these concerns.
- The client's significant others i.e. friends and/or family members and their (if any) attitudes and concerns with food, weight, dieting, health and appearance (include family history of eating disorders).
- Significant events (if any) (such as traumatic events, choking episodes, negative eating experiences etc.
- Any impairment resulting from the eating problem (i.e. social eating concerns, physical health concerns, preparing food, other).

Client’s view on what maintains current eating difficulties/eating disorder behaviours?

Anthropometry:

Current weight:

Height:

BMI:

Goal weight (of client if present):

Weight history and views on weight/shape:

Weight over the past 6 months (circle): maintained/increasing/decreasing/fluctuating (between ___kg & ___kg)

Premorbid weight ___________ kg (BMI:) When? ___________

Highest weight ___________ kg (BMI:) When? ___________ For how long? ___________

Lowest weight ___________ kg (BMI:) When? ___________ For how long? ___________

Frequency of weighing:

Body checking behaviours/frequency:

Are you happy with your current weight/body shape? Yes ☐ No ☐

If no, what would you like to see different, what would that look like?

Major causes of body dissatisfaction?

(e.g. comparisons/environmental influences e.g. work, school, sport)

Age when first began worrying about weight: ______________________

Age when eating disorders behaviours first began: ______________________

Known trigger(s):

Usual body shape within family:

Other comments made by client and/or family members during this section:

Biochemistry:

Date	BGL	Na	K	Urea	Creat	PO4	Mg	C.Ca	Alb	Hb	eGFR	Lymph	Neutrophils

LFTs – ALT, AST, GGT, Alk Phos
HbA1c

BP (Sitting/Standing): ______________________ HR (Sitting/Standing): ______________________

Temperature or cold/blue extremities: ______________________

ECG results: ______________________

Bone mineral density results if available: ______________________

Menstrual status (females): ________________ Regular periods? ______________________

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Clinical concerns:
(including appetite, nausea, bowels, allergies, other issues):

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Dietary information:

Disordered Eating Behaviours Present:

Any Dieting Behaviours (such as calorie counting, macronutrient restriction, food group avoidance, following a particular diet (vegan/vegetarian or other), skipping meals, playing with food, food guilt

Binge-eating, Purging and Compensatory Behvaiours (include type, quantity, frequency, triggers, age when commenced):

Binge-eating: Yes ☐ No ☐

Diuretics: Yes ☐ No ☐

Self-induced vomiting/purging: Yes ☐ No ☐

Diet pills (including duromine): Yes ☐ No ☐

Laxatives: Yes ☐ No ☐

Other (e.g spitting out food, hiding food, fibre): Yes ☐ No ☐

If assessing binge eating, please ask the client to describe what a 'binge' looks like, and be sure to include any associated thoughts or feelings present before, during and after the 'binge':

Binge eating:

Specific day(s) of the week?

Specific time(s) of the day?

Specific place(s):

Known triggers:

Type/Amount food typically eaten during a binge:

Food and fluid intake: (incl times and duration of meal time if relevant)
What does a typical day's food and fluid intake look like?

B: ______________________ AT: ______________________

MT: ______________________ D: ______________________

L: ______________________ S: ______________________

Avoided 'unsafe' foods:

Avoidance of (circle): red meat/poultry/fish/eggs/dairy/grains/other foods

From what age: ______________________ Why? ______________________

Following a particular kind of diet? (e.g. Vegetarian, Vegan, Paleo, Keto etc):

Yes ☐ No ☐ If yes, which one? ______________________

Any food allergies: ______________________ Meals usually prepared by: ______________________

Fluid intake: ______________________ Chewing gum: ______________________

Weekend variation: ______________________

Current Exercise:

Type: ______________________ Quantity: ______________________

Frequency: ______________________

What is your main motivation to exercise? ______________________

Do you feel a current compulsion to exercise? No ☐ Yes ☐ (From what age?) ________

If yes, please describe in more detail. ______________________

Do you compensate for your food intake with exercise? No ☐ Yes ☐

Clients aim for intervention/motivation to change:

Clients nutrition goals:

Is there anything else?
(Is there anything else the client would like to add that is important to know?)

Estimated Energy Requirements (based on weight of ________) (not shared with client):

EER: ____________________ EPR: ____________________

EFR: ____________________

Nutrition diagnosis (PES):

Nutrition intervention (if this occurred at assessment):

Plan (both general plan and if indicated a safety/crisis plan) and follow up