Diabetes Control Center

Medical Nutrition Therapy Assessment Form

Name:____ Age:__________ D.O.B.________________

Name of referring physician: ______________________ Date and time of your appointment: ________________

Medical Diagnosis: ______________________ Other medical/surgical history: __________________________

What are you hoping to receive from this appointment? ____

Do you have a pacemaker or other implants? ☐ Yes ☐ No Could you be pregnant? ☐ Yes ☐ No

Height: ________ Biometric scale: ☐ Yes ☐ No **Weight:** __________

If pregnant, pre-pregnancy weight: _____ Weeks of gestation: ____ Are you pregnancy with twins or triplets? ☐ Yes

Any weight changes in the past 6 months? ___________ What weight are you most comfortable with? __________

For individuals with Diabetes: Do any family members have diabetes? ☐ No ☐ Yes, who? __________________

Blood glucose range before meals: ________________ Blood glucose range after meals: ___________________

Insulin to carb ratio: ☐ No ☐ Yes _____________ Insulin correction factor: ☐ No ☐ Yes _____________

Food and Nutrition: Please check all that apply to your current eating routine

☐ Vegetarian ☐ Gluten-free ☐ Low fat ☐ Low sodium ☐ Keto ☐ Low carb ☐ Low fiber/gastroparesis diet

☐Count carbs ☐ Skip meals ☐ Mid-night snacks ☐ Stress/Boredom eating ☐ Binge eating ☐ Not eating

☐ Sugary beverages: soft drinks, sweetened tea ☐ Sweets/high calorie snacks: candy, desserts, chips

☐ Fried/fatty foods: bacon, cheese, red meats ☐ Salty foods: Salt shaker, canned/processed foods, luncheon meats

☐ Vitamins/mineral supplements ☐ Probiotics ☐ Nutritional shakes

☐ Other ____

Food allergies: ☐ Fish/shellfish ☐ Peanuts/tree nuts ☐ Wheat/gluten ☐ Milk/lactose ☐ Soy ☐ Other ______

Which foods do you avoid? Why? ____________________________How much water do you drink daily? _____

Do you drink alcohol? ☐ No ☐ Yes, type and frequency? ____

Do you have any cultural/ethnic practices or any religious or spiritual beliefs that may impact your care? ___________

Number of times you eat out each week? _____ Places you eat out most? ___________________________

Food Assistance: ☐ No ☐ Yes ___________ Who does food shopping and cooking? ____________________

Cooking method mostly used? ☐ Pan-fry ☐ Deep-fry ☐ Air-fry ☐ Grill ☐ Bake ☐ Steam

Is your daily intake low in? **Fruits:** ☐ less than two **Vegetables:** ☐ less than two **Milk/yogurt** ☐ None

Patient Label

DCCAST

Diabetes Control Center

In the boxes below, please write the time you eat and what you eat and drink for meals and snacks

Time	Time	Time	Time	Time	Time

Exercise: ____ How often? _______ Length of time? ________

Medication allergies: ____

Preferred Language: ____________________________________ Rate your reading skills: ☐ Good ☐ Fair ☐ Poor

Use computers to search for health information or e-mail? ☐ Yes ☐ No

How do you prefer to communicate? ☐ Verbal ☐ Written ☐ Other ________________________________

Do you use any of the following? ☐ Contacts ☐ Eye glasses ☐ Hearing aids ☐ Other ___________________

Highest education level? ☐ Grade school ☐ High school ☐ College ☐ Post graduate ☐ Skills trade

Preferred learning style: ☐ None ☐ Demonstration ☐ Print ☐ Verbal explanation ☐ Video ☐ Other

Occupation: _________________________________ Work schedule: ______________________________________

My stress level is: ☐ Low ☐ Moderate ☐ High List factors: ____

Hours of sleep: ☐ <7 ☐ 7-9 ☐ >10 Time you go to sleep? _____________ Time you wake up? ______________

Do you currently smoke? ☐ Never ☐ No (Year quit? ____) ☐ Yes Type? ☐ Cigarettes ☐ Cigars ☐ Vaping

Do you feel safe at home? ☐ Yes ☐ No Fallen in the past 3 months? ☐ Yes ☐No

Dizziness or vertigo? ☐ Yes ☐ No Ever wet or soil yourself on the way to the bathroom? ☐ Yes ☐ No

Pain? ☐ Yes ☐ No Location? _______ Intensity (0-10)? _____ Who manages your pain? ____________________

For Office Use Only:

Goals: ____

Nutrition Diagnosis: ____