EVALUATION FORM - INSURANCE

Name: Date:

Address:

City: State: Zip:

Email: Phone: Referred by (Name or Code):

Employer: Primary Physician: Physician Phone:

DOB: Sex: ☐Male ☐Female Height:

Current Weight: Desired Weight: Current BF%:

Body Measurements in Inches for each area:

Waist - Measure at belly button
Hips - Legs together and widest area around the buttocks
Neck - Around the Adam's apple or mid-neck region

Have you ever been seen by a Registered Dietitian before? ☐ Yes ☐ No
If so, when was the last visit:

GOALS

Number your Goals below 1-5 (1 being most important)
Improve my eating habits
Improve my muscle mass
Get rid of excess body fat
Have more energy
Increase Athletic Performance

Specific Goal to achieve (ie. Event):

Have you tried achieving the above goals in the past? ☐Yes ☐ No

If yes, please list:

Method	**Outcome**	**Likes**	**Dislikes**
1)			
2)			
3)			

What has been your biggest challenge achieving this goal:

NUTRITION

Record the following amount of beverages (per 8oz) you consume per week:

Regular Soft Drink	Diet Soft Drink	Coffee
Sweet Tea	Alcoholic Beverage	Water

The meal I tend to skip most often is: ☐Breakfast ☐Lunch ☐Dinner

My biggest meal of the day is: ☐Breakfast ☐Lunch ☐Dinner

Times I eat and what I typically eat

Meal	**Time**	**I normally eat:**
Breakfast:		
Lunch :		
Dinner:		
Snacks:		

The foods I tend to crave the most are:

☐Meat & Poultry ☐Breads & Baked Goods ☐Foods with Heavy Sauces
☐Salty Foods ☐Hot & Spicy ☐Fried Foods ☐Sugar & Sweet

Below is a list of common food choices. Please go through and check the food items you prefer *NOT* to have included for meal planning purposes.

Fruit	**Vegetables**	**Grains/Starchy Vegetables**
☐Cantaloupe	☐Tomato	☐Rice
☐Watermelon	☐Broccoli	☐Pasta Noodles
☐Apple	☐Zucchini	☐Bagels
☐Banana	☐Mushrooms	☐Oatmeal
☐Orange	☐Lettuce	☐Grits
☐Strawberry	☐Carrots	☐Potatoes
☐Pear	☐Cucumber	☐Sweet Potato
☐Grapefruit	☐Cauliflower	☐Corn
☐Grapes	☐Onion	☐Beans
☐Peach	☐Celery	☐Whole wheat bread
☐Pineapple	☐Spinach	☐Pretzels
☐Unsweetened Fruit	☐Juice	☐Crackers
		☐Cold Cereals
Meat/Meat Substitute	**Dairy**	**Fat**
☐Chicken	☐Skim Milk	☐Bacon
☐Tofu	☐1% Low Fat Cheese	☐Margarine
☐Fish	☐Low Fat Yogurt	☐Butter
☐Sirloin	☐Low Fat Cottage Cheese	☐Peanuts
☐Cheese (Low-Fat)		☐Salad Dressing
☐Lean Roast Beef		☐Seeds
☐Lean Ham		☐Sour Cream
☐Low-Fat Deli Meats		☐Cream Cheese
☐Beans		
☐Eggs		

Other Food Items not mentioned above:

What is the biggest challenge that most effects your nutrition? (check all that apply)

☐I get bored of eating healthy foods
☐I cook for my family
☐I eat out often
☐I do not do well under social influence
☐Other:

EXERCISE

How often do you currently exercise? (check one)

☐5-7 times a week ☐1-3 times a week
☐3-5 times a week ☐Never

My work or daily activity primarily involves the following (check one)

☐Sitting ☐Walking Actively
☐Standing ☐Heavy Labor

My aerobic exercise of choice is (check all that apply)

☐Walking ☐Running ☐Outdoor Biking
☐Stair Climber ☐Group Fitness ☐Stationary Bike
☐Elliptical ☐None ☐Other:

My Strength Training of choice is (check all that apply)

☐Home Equipment ☐Weight Machines ☐Free Weight
☐Hand Weights ☐Plyometrics ☐Core
☐Functional ☐None ☐Other:

Any additional information you wish to provide:

HEALTH

Please check all health conditions that you currently have if any:

☐Diabetes Taking insulin: ☐Yes ☐No
☐Heart Disease Type:
☐Kidney Disease Stage:
☐Celiac Disease
☐Stroke (within last 6m)
☐Cancer Stage:
☐Diverticulitis
☐Osteoporosis
☐Eating Disorder (w/in 6m) Details:
☐Sleep Apnea
☐High Blood Pressure Reading:
☐High Cholesterol Number:
☐Pregnant/Nursing
☐Under age 18
☐Other: please specify

Please check any specific dietary needs that you may require:

☐Gluten Free
☐Lactose Intolerance
☐Vegetarian Type:
☐Food allergies Type:
☐Other: please specify

Are you currently under a physicians care for any health reason? ☐Yes ☐No
If so please list:

Are you currently taking any medications and/or supplements? ☐Yes ☐No

If **yes**, please list names, dosage amounts and time of day:

Type	**Dosage**	**Time of Day**

Any additional Health information you would like to share?

HEALTH RISK CATEGORIES: TNT Health Educator/RD Use Only (check one box)

☐**Low**

- 18 years or older with no known health problems or medical conditions
- BMI 20-30 kg/m*2*

OR

- < 18 years of age with parental permission and no known health problems or medical conditions requiring direct medical monitoring and or supervision

☐**Moderate**

- < 18 yrs or older with a BMI of > 25 *kg/m2*

OR

- 18 years or older *with a B*MI of *30-35kg/m2*
- Waist circumference equal to 35" in females or 40" in males
  and one or more of the following; (1) obesity related diseases, or (2) cardiovascular risk factors listed by the "Health Status and Conditions".

☐**High**:

- BMI: >35 *kg/m2*
- Waist circumference greater that 35" in females or 40" in males
  and one or more of the following; (1) obesity related diseases, or (2) cardiovascular risk factors listed by the "Health Status and Conditions."