Confidential

Client Assessment

Name __________________________ Initial/Final

Record ID

DATE of Client Assessment

Name of Staff that performed Assessment:

(First and Last Name)

Which assessment is this:

☐ Initial
☐ Final

Weight (lbs)

(lbs 1 decimal places)

Has your doctor recommended a diet for you to follow?

☐ a. Yes
☐ b. No
☐ c. Unsure

What kind of diet?

☐ a. Diabetic/ low carb
☐ b. Heart healthy (low sodium, low fat)
☐ c. Regular/Eat balanced
☐ d. Diet to lose weight
☐ e. Other
☐ f. None

If other, what kind

Do you currently take any

☐ a. Vitamin replacement
☐ b. Meal Replacement
☐ c. None of the above
   If yes, please specify

Have you lost weight in the last 3 months?

☐ a. Yes
☐ b. No
☐ c. Unsure

If yes, how many (lbs)

Why did Weight Loss occur?

☐ a. Intentional
☐ b. Due to medical conditions
☐ c. Other
   If other, please specify

Your appetite is

☐ a. Poor
☐ b. Fair
☐ c. Good
☐ d. Excellent

How many meals do you typically eat in a day?
<table>
<thead>
<tr>
<th>Question</th>
<th>Options</th>
</tr>
</thead>
</table>
| If less than 3, why do you not eat more in one day?                      | a. Cannot afford  
  b. Makes me feel ill  
  c. No way to get to grocery store  
  d. Just not hungry  
  e. Too much trouble to fix |
| Do you eat alone most of the time?                                      | Yes  
  No |
| Do you take 3 or more different prescribed or over the counter drugs a day? | Yes  
  No |
| Names of medicine                                                       | a. Blood pressure  
  b. Diabetic  
  c. Heart  
  d. Not answered  
  e. Other  
  If other, please specify |
| Are you physically able to shop, cook, or feed yourself?                | a. Yes  
  b. No  
  c. Need assistance |
| I have                                                                 | a. Physical handicap  
  b. Chewing/swallowing problems  
  c. Other |
| How often do you use a cell phone, computer, iPad, or other electronic device each day? | a. 1-3  
  b. 4-8 times  
  c. More than 8 times  
  d. None |
| Do you have a standardized size refrigerator?                           | Yes  
  No  
  N/A |
| In the last three months, how many unplanned doctor's visit did you have? | a. 1-3 visits  
  b. More than 3 visits  
  c. None |
| Reasons for doctor's visits                                             | a. Routine/Wellness/Annual  
  b. For medical condition(diabetes, BP, heart disease)  
  c. Other  
  If other, please specify |
| Do you also get food from food pantries or other community resources?    | Yes  
  No |
| I also receive food assistance sometimes from                            | a. Local food pantries  
  b. Community provided meals |
| Do you have any food allergies or food dislikes?                        | Yes  
  No  
  N/A |
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| **I have these Food allergies that may cause life threatening reactions** | ☐ a. Shellfish  
☐ b. Wheat  
☐ c. Nuts  
N/A |
| **Medical conditions** | ☐ a. Diabetes, pre-diabetes  
☐ b. Heart disease  
☐ c. High blood pressure  
☐ d. Cancer  
☐ e. Overweight/Obesity  
☐ f. None |
| **Diet Order** | ☐ a. Diabetic  
☐ b. Heart Healthy (low fat, low sodium)  
☐ c. Weight Loss  
☐ d. Weight Gain  
☐ e. Regular |
| **Practicing Hospital of PCP** | ☺ a. Eskenazi Health  
☐ b. Other  
If other, please specify |