UNIVERSITY OF MIAMI
PATTI & ALLAN HERBERT
WELLNESS CENTER

Dietary Assessment

Name (First & Last):
Age:
Height: **Weight:**

I live: ☐On Campus ☐Off Campus Year In School: _____
(freshman, sophomore, junior, senior, grad student)

Major: _____
Referred by: _____ (self, healthcare provider, etc.)

Have you seen a Nutritionist before? ☐ Yes ☐No If yes, why and when _____

Are you on a special diet? _____
(Gluten-free, vegan, vegetarian, low FODMAP, low cholesterol, kosher, etc.)
Food Allergies or intolerance: _____
What foods do you avoid: _____
Why do you want to see a Dietitian?

☐Healthy meal planning
☐Concern about weight gain in college
☐Healthy weight loss
☐Healthy weight gain
☐Sports nutrition
☐Stress over/ under eating
☐Dining hall over/ under eating
☐Hunger management
☐Food allergies or intolerances
☐Gastrointestinal disorder (IBS, Colitis)
☐Vegetarian/vegan
Other: _____

Do you drink alcohol? ☐Yes ☐ No Do you smoke? ☐Yes ☐ No ☐ Recently quit
if yes, how many times a week and per sitting? _____
Do you currently exercise? ☐ Yes ☐No
How many times a week and for how long? _____

List any prescribed, over the counter, herbal or vitamin supplements you take:

_____
_____
_____

To tailor this counseling experience to your needs, we would like to know your expectations. Please indicate the amount of structure you believe meets your needs, choose one:

☐ Tell me exactly what to eat for all my meals and snacks. I want a detailed food plan.
Example: ½ cup oatmeal, 1 cup blueberries, 1 tablespoon peanut butter, 2 hard boil eggs
☐ I want a lot of structure but freedom to select foods. I want to use the exchange system.
Example: 1 milk, 2 starches, 1 fruit, and 1 fat exchange
☐ I want some structure and freedom to select foods. I want to use a food group plan.
Example: 1 serving of dairy foods, fruits, and fat and oil group; 2 servings of grains
☐ I don't want a diet. I just want to eat better and set goal each session.

Please add any additional information you feel may be relevant to understanding your nutritional health (chronic disease, prior surgeries, etc.)

_____
_____
_____

Complete short Food Frequency Questionnaire per day and/or per week to the best of your abilities:

Food Group	Serving Sizes	Serving per day	Serving per week	Never/ rarely
Refined Grains: white bread pasta, cereals OR Whole Grains: whole wheat bread, brown rice, quinoa, oatmeal	1 Slice bread 1 cup cereal 1/2 cup cooked rice, pasta or cereal 1/2 bagel English muffin			
Vegetables	1 cup raw leafy vegetable 1/2 cup cooked or raw vegetables 6oz vegetable juice			
Fruits	1/2 cup juice medium fruit 1/4 cup dried fruit 1/2 cup fresh, frozen, or canned fruit			
Low Fat dairy OR Whole fat dairy	8 oz. milk 1 cup yogurt 1 oz. cheese or 1 slice			
Lean meats, poultry, fish OR High fat meats, sausage, cold cuts, bacon, ribs	3 oz.			
Nuts, seeds, dry beans	1/4 cup nuts 2 tbsp. seeds 1/2 cup cooked dry beans 4oz tofu 1 cup soy milk 2 tbsp. nut butter			
Fats and oils	1 tbsp. regular dressing 2 tbsp. light dressing 1 tsp. oil 1 tbsp. mayo 1 tsp. butter			
Sweets	1.5 oz. candy (bag of M&Ms) Cookies (2 cookies Oreo size)			
Alcohol	12 oz. beer 5oz wine 1 shot spirits			