XYZ HHA
NUTRITIONAL ASSESSMENT

Name:_____D.O.B._____Age:_____PID#_____
Physician:_____ Cert. Period:_____to_____Date:_____
Cardiac Recovery Program: Y____ N____

Diagnosis/Medical History:_____

Height:_____ Body Frame: Small____ Med_____ Large_____
Weight:_____ Body Mass Index:_____
Desired Weight:_____ Other:_____
Usual Weight:_____ _____
Weight Pattern:_____

Dental: _____ Chewing: _____ Hearing: _____ Ambulatory: _____

Mouth Pain: _____ Swallowing: _____ Vision: _____ Nonambulatory: _____

Speech: _____

Caloric Requirements:_____
_____
Labs:_____
Bowel Function:_____
_____

CLINICAL
Medical Diagnosis with Dietary Implications:_____
_____
_____
_____
Medication with Dietary Implication:_____
_____
_____
_____
_____
_____
Skin:_____

Nutrition Risk Score _____

DIET INFORMATION:
Type:_____
_____
Texture Modification:_____
Nutritional Supplements:_____
Food Allergies:_____
Appetite:_____
Assistance with: Feeding____ Cooking____ Shopping____ Eats alone____

24 HOUR DIET RECALL:

-
-
-
-
-
-
-
-

___AHA Step 1
___Diabetes
___Dining out
___Label Reading / Shopping
___Recipe Modification
___RD Follow Up

Client Signature _____

Time of Visit _____ a.m./p.m. to _____ a.m./p.m.

SIGNATURE:_____ DATE:_____