Date: _____

Name: _____ **Patient Acct No. :** _____

Address: _____

Phone: _____ **Referred By:** _____

Diagnoses: _____

Reason for Referral: _____

24 HOUR FOOD RECALL					
First Meal		Second Meal		Third Meal	
Food	Amount	Food	Amount	Food	Amount
Between Meals		Between Meals		Between Meals	

Who Cooks?	❍ Restaurant ❍ Fast foods ❍ Take out / carry out / take away	❍ Self ❍ Family ❍ Care-giver
Smoking	❍ Yes	❍ No
Recreational Drugs	❍ Yes	❍ No
Physical Activity	❍ Yes *(Specify)*	❍ No
Comments		

FOOD FREQUENCY			
How often do you eat the following foods?	**Daily**	**Sometimes**	**Never**
Milk, yogurt, cheese	❍	❍	❍
Ice cream	❍	❍	❍
Meat, fish, chicken, eggs	❍	❍	❍
Peanut butter, nuts, rice and beans, tofu	❍	❍	❍
White bread, bagels, sweet cereal, rice, pasta, potatoes	❍	❍	❍
Wheat / rye bread, brown rice, whole grain pasta, oatmeal / grits, whole grain cereal	❍	❍	❍
Vegetables, salad	❍	❍	❍
Fruits	❍	❍	❍
Juices, lemonade, juice drinks	❍	❍	
Snacks (chips, pretzels, cookies, cakes, candy)	❍	❍	❍
Water	❍	❍	❍
Coffee, tea, seltzer, plain iced tea, diet soda,	❍	❍	❍
Snapple, Malta, sports drinks	❍	❍	❍
Beer, wine, liquor, mixed drinks	❍	❍	❍
Butter, oil, cream cheese, mayonnaise, gravy, fried food	❍	❍	❍

COMMENTS

❍ No plan for eating
❍ No variety
❍ Other:

ASSESSMENT

Risk Factors (*check all that apply*)	
❍ limited financial resources ❍ food insecurity	❍ lives alone ❍ no support system
❍ unable to cook ❍ unable to shop	❍ no cooking facilities ❍ limited access to food
❍ psychosocial issues ❍ cognitive impairment	❍ depression ❍ mental illness
❍ pain ❍ fatigue	❍ needs assistance with ADLs ❍ needs assistance with IADLs
❍ poor dentitian ❍ needs dental care	❍ swallowing problems ❍ poor appetite
❍ weight gain ❍ nausea ❍ constipation	❍ weight loss ❍ vomiting ❍ diarrhea
❍ visual impairment ❍ difficulty reading	❍ caregiver with visual impairment ❍ caregiver unable to read
❍ Rx, OTC, supplements affecting GI symptoms and/or nutritional status (specify)	
❍ lactose intolerance ❍ food intolerances(specify)	
Current intake (*check all that apply*) ❍ adequate ❍ inadequate in ❍ fluid ❍ calcium ❍ protein ❍ fruits ❍ vegetables ❍ grains ❍ fiber ❍ excessive in ❍sweets ❍sweet drinks ❍alcohol ❍salty snacks ❍fast foods ❍caffeine ❍other ❍ skips meals ❍ large portions ❍ unplanned	
❍ Smoking	
❍ Recreational Drugs	
❍ Physical Activity	
Other:	

RECOMMENDATIONS (*check all that apply*)		
Referral to	❍ Social Service ❍ Nutritionist ❍ Occupational Therapist ❍ Physical Therapist	❍ Mental Health ❍ Speech-Language Pathologist ❍ Smoking Cessation Program ❍ Low Vision Specialist ❍ Other
Increase:	❍ fluid ❍ calcium ❍ protein ❍ fruits	❍ vegetables ❍ fiber ❍ physical activity
Decrease:	❍ sweets ❍ sweet drinks ❍ alcohol ❍ salty snacks ❍ fast food ❍ fried foods ❍ portions ❍ caffeine	
❍ Eat at regular times ❍ Eat more frequently		
Assist with	❍ food choices ❍ meal planning ❍ educate caregiver ❍ shopping ❍ cooking ❍ obtaining Meals on Wheels	
Increase supervision:	❍ home health aide ❍ day program ❍ assisted living ❍ skilled nursing facility	
Discontinue supplement _____ Consider supplement for _____		

Other:

_____

_____

_____

_____

Intervention:

_____

_____

_____

_____

Signature: _____ Date: _____

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