

Nutrition Assessment

GETTING STARTED

	Very poor health	Excellent health
a. Please circle your current overall LEVEL OF HEALTH .	0 1 2 3 4 5 6 7 8 9 10	
b. Please rank the top 3 areas you would like to improve with 1 being the most important and 3 the least important.		
Sleep _____	Weight Management _____	Nutrition _____
Exercise _____	Purpose & Connection _____	Mental Health _____
Substance Use _____		
	Not important at all	Very important
c. How IMPORTANT is it for you to make the change you ranked as the #1 most motivated topic area to address?	0 1 2 3 4 5 6 7 8 9 10	
d. How CONFIDENT are you regarding your ability to make the change you ranked as the #1 most motivated topic area to address?	0 1 2 3 4 5 6 7 8 9 10	
e. How IMPORTANT is it for you to make the change you ranked as the #2 most motivated topic area to address?	0 1 2 3 4 5 6 7 8 9 10	
f. How CONFIDENT are you regarding your ability to make the change you ranked as the #2 most motivated topic area to address?	0 1 2 3 4 5 6 7 8 9 10	
g. How IMPORTANT is it for you to make the change you ranked as the #3 most motivated topic area to address?	0 1 2 3 4 5 6 7 8 9 10	
h. How CONFIDENT are you regarding your ability to make the change you ranked as the #3 most motivated topic area to address?	0 1 2 3 4 5 6 7 8 9 10	
i. What would you like to gain from this lifestyle visit? <i>Check all that apply</i>		
<input type="checkbox"/> More medical/scientific knowledge	<input type="checkbox"/> Practical health tips	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Accountability	<input type="checkbox"/> Personalized plan	

Patient Name: _____ DOB: _____



The 4Leaf Survey

For estimating the percent of your calories from whole plants

As you know, 4Leaf for Life was designed to help people everywhere leverage the simple, yet powerful, concept of maximizing the percentage of their calories from whole, plant-based foods — still in nature’s package. This survey identifies your current 4Leaf “level” of eating. Note that even the 1-Leaf level is in the top 10% — when it comes to healthy eating. These 12 questions will give you a pretty good idea of how you can improve your score.

The 4Leaf Survey

Take 2 minutes, be honest, circle your answers and tally your score. (A serving = about 1/4 of a plate)

1	FRESH FRUIT. On average, how many daily servings of whole fresh fruit do you eat? (Fruit juice doesn’t count; not a whole plant)	0	1-2	3-5	6+
2	WHOLE VEGETABLES. On average, how many daily servings of whole vegetables do you eat?	0	1-2	3-5	6+
3	WHOLE GRAINS, LEGUMES, POTATOES or other starches. On average, how many daily servings of these foods do you eat?	0	1-2	3-5	6+
4	OMEGA-3s. Are you getting all you need from whole, plant-based sources like flaxseeds, walnuts, hemp & chia seeds?	No	Maybe	Not Sure	Yes
5	DAIRY FOODS. How many days per week do you eat dairy foods like cheese, yogurt and ice cream? (Soy does not count)	0	1-2	3-5	6-7
6	EGGS. How many days per week do you either eat eggs or add them as an ingredient when cooking?	0	1-2	3-5	6-7
7	COW’S MILK OR CREAM. How many days per week do you drink them or add to your food, like cereal, coffee, etc.?	0	1-2	3-5	6-7
8	ADDED SUGAR. Are you really serious about eliminating added sugar at home and in food products that you buy?	You bet	Fairly	Not Very	No
9	WHITE FLOUR. Bread, pasta, cakes, cookies, etc. How would you describe your consumption level of these foods.	Zero	Light	Medium	Heavy
10	SWEETS & SALTY SNACKS. How would you best describe your consumption level of these unhealthy foods.	Minimal	Light	Medium	Heavy
11	MEAT, POULTRY AND FISH. How many of your meals per week include any animal flesh? (beef, pork, lamb, chicken, turkey or fish)	0-1	2-5	6-11	12+
12	VEGETABLE OIL. How many of your meals per week include vegetable oil, like olive or canola? (All oil is 100% fat, not whole plant)	0-1	2-5	6-11	12+

Patient Name: _____ DOB: _____

NUTRITION

EATING PATTERNS

Please answer based on your typical eating habits

- | | | | | | |
|---|---|---|---|----|-----|
| a. On average, how many cups (8 oz.) of caffeinated beverages do you drink per day (tea, soda, coffee, or energy drinks)? | 0 | 1 | 2 | 3 | 4+ |
| b. On average, how many servings of alcohol do you drink per day ? | 0 | 1 | 2 | 3 | 4+ |
| c. On average, how many cups (8 oz.) of sugary drinks (soda, sports drinks, juice) do you drink per day ? | 0 | 1 | 2 | 3 | 4+ |
| d. On average, how often do you snack on convenience or “junk” food per day ? (i.e. chips, candy, granola bars, crackers, cookies, etc.) | 0 | 1 | 2 | 3 | 4+ |
| e. On average, how many meals do you buy from a restaurant or fast food per week ? | 0 | 1 | 2 | 3 | 4+ |
| f. On average, do you drink at least 8 glasses of water per day ? | | | | No | Yes |
| g. On average, do you eat at least 5 handfuls of nuts per week ? | | | | No | Yes |
| h. Do you use natural or artificial sweeteners? (i.e. Equal, Stevia, Splenda, Sweet & Low, honey, agave, etc.) | | | | No | Yes |
| i. Do you add salt to most of your meals? | | | | No | Yes |
| j. Do you eat processed meats (i.e. sausage, hot dogs, salami, bacon)? | | | | No | Yes |
| k. Do you have any bad reactions (sensitivities or allergies) to food? If yes, please list here: _____ | | | | | |
| l. Do you avoid any particular foods? If yes, please list here: _____ | | | | | |
| m. Do you have foods that you crave? If yes, please list here: _____ | | | | | |
| n. Are you currently following a particular diet or nutrition plan? If yes, please list here: _____ | | | | | |
| o. During the last 3 months, did you have any episodes of excessive overeating? If yes please explain here: _____ | | | | | |
| p. Are you concerned about making the wrong food choices? If yes, please explain here: _____ | | | | | |
| q. Have you ever had an eating disorder? If yes, please list here: _____ | | | | | |

Do you use any of the following VITAMINS or SUPPLEMENTS? Check all that apply

- | | | |
|-------------------------------------|----------------------------------|---------------------------------------|
| <input type="checkbox"/> Vitamin D | <input type="checkbox"/> Calcium | <input type="checkbox"/> Vitamin B12 |
| <input type="checkbox"/> Probiotics | <input type="checkbox"/> Omega 3 | <input type="checkbox"/> Multivitamin |
| Other: _____ | | |

Do you use any of the following OILS with your meals or cooking? Check all that apply

- | | | |
|--------------------------------------|-------------------------------------|--|
| <input type="checkbox"/> Olive Oil | <input type="checkbox"/> Canola Oil | <input type="checkbox"/> Vegetable Oil |
| <input type="checkbox"/> Coconut Oil | <input type="checkbox"/> Butter | <input type="checkbox"/> Lard |
| Other: _____ | | |

FOOD RECALL: Please record below what AND how much you ate and drank yesterday (or the last typical day)

- Breakfast: _____ Time: _____
- Lunch: _____ Time: _____
- Dinner: _____ Time: _____
- Snacks: _____ Time: _____
- Drinks/Beverages: _____ Time: _____

Patient Name: _____ DOB: _____

WEIGHT MANAGEMENT

BEHAVIOR PATTERNS

	Never	Seldom	Sometimes	Often	Always
a. How often do you skip meals?	1	2	3	4	5
b. How often do you snack in between meals?	1	2	3	4	5
c. How often do you eat while watching TV?	1	2	3	4	5
d. How often do you eat while in bed?	1	2	3	4	5
e. How often do you have difficulty sleeping?	1	2	3	4	5
f. How often do you lack physical activity or exercise?	1	2	3	4	5
g. How often do you feel a lack of purpose or meaning in your life?	1	2	3	4	5

Which of the following factors apply to your eating habits and current lifestyle? *Check all that apply*

- | | | |
|--|--|---|
| <input type="checkbox"/> Like healthy food | <input type="checkbox"/> Don't like healthy food | <input type="checkbox"/> Know how to cook healthy foods |
| <input type="checkbox"/> Fast eater | <input type="checkbox"/> Eat slowly | <input type="checkbox"/> Read nutrition labels |
| <input type="checkbox"/> Rely on packaged or fast foods | <input type="checkbox"/> Dislike cooking | <input type="checkbox"/> Prepare meals at home |
| <input type="checkbox"/> Do not plan meals | <input type="checkbox"/> Eat a variety of foods | <input type="checkbox"/> Always hungry |
| <input type="checkbox"/> Late night eater | <input type="checkbox"/> Negative relationship to food | <input type="checkbox"/> Erratic eater |
| <input type="checkbox"/> No time to prepare healthy food choices | <input type="checkbox"/> Don't know how to cook | <input type="checkbox"/> Live alone or eat alone often |

Do any of the following situations or emotions cause you to eat? *Check all that apply*

- | | | | |
|----------------------------------|--|-----------------------------------|----------------------------------|
| <input type="checkbox"/> Sadness | <input type="checkbox"/> Pain | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Social or Family Situations | <input type="checkbox"/> Boredom | <input type="checkbox"/> Stress |

Patient Name: _____ DOB: _____

WEIGHT MANAGEMENT (continued)

WEIGHT HISTORY

- | | | |
|---|----|-----|
| a. Have you ever been overweight or obese? If yes, answer below: | No | Yes |
| Were you overweight as a child? | No | Yes |
| Were you overweight as a teenager? | No | Yes |
| Were you overweight between the ages of 20-29? | No | Yes |
| Were you overweight between the ages of 30-39? | No | Yes |
| Were you overweight above the age of 40? | No | Yes |
| b. Are you currently trying to lose or gain weight? | No | Yes |
| If yes, please circle your goal: Lose weight Gain weight | | |
| c. Have you ever intentionally lost or reduced your weight by more than 5 lbs.? | No | Yes |
| If yes, did you regain weight within 1 year? | No | Yes |
| d. Have you had weight loss surgery? | No | Yes |
| If yes, please list the type of surgery you had: _____ | | |

Have you ever used weight loss medications? *If yes, circle which ones you have used? If other, please list.*

- | | | | | | | |
|--------------------------------------|-----------------------------------|--|---------------------------------------|----------------------------------|----------------------------------|-----------------------------------|
| <input type="checkbox"/> Acutrim | <input type="checkbox"/> Alli | <input type="checkbox"/> Amphetamines | <input type="checkbox"/> Anorex | <input type="checkbox"/> Belviq | <input type="checkbox"/> Byetta | <input type="checkbox"/> Contrave |
| <input type="checkbox"/> Dexatrim | <input type="checkbox"/> Didrex | <input type="checkbox"/> Fastin | <input type="checkbox"/> Fenfluramine | <input type="checkbox"/> Mazanor | <input type="checkbox"/> Meridia | <input type="checkbox"/> Obalan |
| <input type="checkbox"/> Phendiet | <input type="checkbox"/> Fen-Phen | <input type="checkbox"/> Phentermine | <input type="checkbox"/> Plegine | <input type="checkbox"/> Plegine | <input type="checkbox"/> Prozac | <input type="checkbox"/> Pondimin |
| <input type="checkbox"/> Qsymia | <input type="checkbox"/> Redux | <input type="checkbox"/> Sanorex | <input type="checkbox"/> Tenuate | <input type="checkbox"/> Tepanol | <input type="checkbox"/> Vyvanse | <input type="checkbox"/> Wechless |
| <input type="checkbox"/> Wellbutrin | <input type="checkbox"/> Xenical | <input type="checkbox"/> I don't remember the name of the medication | | | | |
| <input type="checkbox"/> Other _____ | | | | | | |

WEIGHT LOSS STRATEGIES

Have you tried any of the following alternative therapies or programs? *Check all that apply. If other, please list.*

- | | | |
|---|--------------------------------------|--|
| <input type="checkbox"/> Acupuncture | <input type="checkbox"/> Acupressure | <input type="checkbox"/> Nutritionist/Registered Dietitian |
| <input type="checkbox"/> Residential Programs | <input type="checkbox"/> Hypnosis | <input type="checkbox"/> Physical Activity/Exercises |
| <input type="checkbox"/> Other _____ | | |

Which commercial or fad diets have you tried in the past? *Check all that apply. If other, please list.*

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Atkins Diet | <input type="checkbox"/> Low Fat | <input type="checkbox"/> Calorie Counting | <input type="checkbox"/> Paleo |
| <input type="checkbox"/> CHIP | <input type="checkbox"/> South Beach | <input type="checkbox"/> DASH | <input type="checkbox"/> Vegan |
| <input type="checkbox"/> Mediterranean Diet | <input type="checkbox"/> Elimination Diet (Allergy) | <input type="checkbox"/> Gluten Free | <input type="checkbox"/> Vegetarian |
| <input type="checkbox"/> Jenny Craig | <input type="checkbox"/> Weight Watchers | <input type="checkbox"/> Low Carb | <input type="checkbox"/> Slim Fast/Meal Replacement |
| <input type="checkbox"/> Other _____ | | | |

Patient Name: _____ DOB: _____