STUDENT HEALTH CENTRE
C.C. Jones Student Services Centre
T 506 453-4837
F 506 452-6087
E sch@unb.ca
go.unb.ca/healthcentre

Nutrition Pre-Assessment Form

Name: _____

Completing this form prior to our appointment will save time during the session and allow us to maximize our time together!

What do you hope to accomplish through a consult with a registered dietitian?

_____

_____

_____

Diet Recall: Please list everything you would eat and drink on a typical day. Please include time of day and amount consumed.

Please describe your activity level. Provide details on amount of physical activity (type, frequency, duration) per week.

_____

_____

Please circle how **confident** you are that you can change your eating behaviors.

NOT VERY CONFIDENT 1 2 3 4 5 6 7 8 9 10 **VERY CONFIDENT**

Please circle how **motivated** your are to change your eating behaviors

NOT VERY MOTIVATED 1 2 3 4 5 6 7 8 9 10 **VERY MOTIVATED**

Please provide any additional information that would be helpful for the dietitian to know.

_____

_____

Anna Jackson, Registered Dietitian
UNB Student Health Center