

Dietary Assessment Form 1

Name Date

WHAT DO YOU USUALLY EAT AND DRINK IN A DAY? (Choose a typical day)

| | Health Professional to complete | | | | | | |
|---|--|--|--------------------------------------|--|---|---|----------------------------------|
| PATIENT TO COMPLETE THESE SECTIONS ONLY PLEASE | Bread/ cereal/ potatoe pasta rice | Fruit & Vegetable include fruit juices | Milk & Dairy yoghurt cheese | Meat, fish & alternative beans/eggs/ nuts/seeds/ lentils | Fats & sugary butter/ spread/ cakes etc | Sodium Salt/Salty foods tinned food crisps/soup | Drinks (including alcohol) |
| What did you eat for: ↓ | | | | | | | |
| BREAKFAST | | | | | | | |
| Mid-morning snacks | | | | | | | |
| MIDDAY MEAL | | | | | | | |
| Afternoon snacks | | | | | | | |
| EVENING MEAL | | | | | | | |
| Evening snacks | | | | | | | |

***IMPORTANT – COFFEE AND ALCOHOL SHOULD NOT COUNT TOWARDS THE DAILY PORTION OF FLUID INTAKE**

TO BE COMPLETED BY HEALTH PROFESSIONAL – Patient’s daily food portions

| | | | | | | | |
|--|------|-----|-----|-----|-----|------|----------------------------|
| PATIENT TOTALS | | | | | | | |
| DAILY PORTIONS | 5-14 | 5-9 | 2-3 | 2-3 | 0-3 | < 6g | > 8 glasses of water |
| AIM FOR (Maintain, Increase or Reduce Portions etc) | | | | | | | |