Albert Pujols Wellness Center
For Adults with Down Syndrome
Nutritional Assessment

Client Information:
First name_____ Last name_____
Date of Birth_____ Residence: ____ private home ____ group housing

Meal Information:
Number of meals daily: _____
Choose one of the following:
Foods are portioned_____
If portioned, are second's available_____
Foods are served "family style" _____
Are you concerned about their portions? _____
Are there any concerns about their diet? _____
Comments_____
Choose one of the following:
Client has some input into foods served_____
Client has total control of foods they choose_____
Client has no input into foods served_____
How often does the client eat out? _____
Comments_____
Choose one of the following:
Client has access to food between meal times_____
Client has no access to food between meal times_____
Does the Client snack? _____ If so how often? _____
Comments_____
Choose one of the following:
Is the client a fast or slow eater? _____
Does the client exercise? _____ If so how often? _____
Would the client be receptive to making changes in their eating habits? _____
Comments_____

Food preferences:
Breakfast Foods:
_____
_____
_____
Lunch/Diner Foods:
_____
_____
_____
Snack Foods:
_____
_____
_____
Beverages:
_____
_____