



Nutritional Assessment Checklist

To be completed by the pet owner. Please answer the following questions about your pet:

Pet's name: _____ Species/breed: _____ Age: _____

Owner's name: _____ Date form completed: _____

- 1 How active is your pet? **Very active** **Moderately active** **Not very active**
- 2 How would you describe your pet's weight? **Overweight** **Ideal weight** **Underweight**
- 3 Where does your pet spend most of the time **Indoor** **Outdoor** **Indoor & Outdoor**

Please list below the brands and product names (if applicable) and amounts of ALL foods, treats, snacks, dental hygiene products, rawhides and any other foods that your pet is currently eating, including foods used to administer medications:

Food	Form	*Amount	Number	Fed since
Examples:				
• Purina Cat Chow	dry	½ cup	2x/day	Jan 2010
• 90% lean hamburger	pan-fried	3 oz (85 grams)	1x/week	May 2011
• Milk Bone medium	dry	2	3/day	Aug 2012
• Greenies Salmon Dental	treat	2	daily	Jan 2013

*If you feed by volume, what size measuring device do you use? _____
 *If you feed tinned/canned food, what size tins/cans? _____

- 4 Do you give any dietary supplements to your pet (for example: vitamins, glucosamine, fatty acids, or any other supplements)? **No** **Yes**

If yes, please list brands and amounts: _____

To be completed by the health care team:

Has the diet history form been reviewed? **No** If not, please review the diet history form **Yes** If yes, please continue:

Current body weight: _____ Ideal body weight: _____

Current body condition score* ____/9 or ____/5 *Refer to the body condition scoring chart

Muscle Condition Score: normal mild wasting moderate wasting severe wasting

Screening evaluation checklist

Pets that are healthy and without risk factors need no additional extended evaluation

Nutritional screening risk factors (extended evaluation is OPTIONAL)	Check <input checked="" type="checkbox"/> if present
Extremely low or high activity level	<input type="checkbox"/>
Multiple pets in a household	<input type="checkbox"/>
Gestation	<input type="checkbox"/>
Lactation	<input type="checkbox"/>
Growth period	<input type="checkbox"/>
Age of >7 years	<input type="checkbox"/>
Nutritional screening risk factors (extended evaluation is MANDATORY)	
History of altered gastrointestinal function (e.g., vomiting, diarrhea, nausea, flatulence, constipation)	<input type="checkbox"/>
Previous or ongoing medical conditions / disease	<input type="checkbox"/>
Currently receiving medications and/or dietary supplements	<input type="checkbox"/>
Unconventional diet (e.g., raw, homemade, vegetarian, unfamiliar)	<input type="checkbox"/>
Snacks, treats, table food > 10% of total calories	<input type="checkbox"/>
Inadequate or inappropriate housing	<input type="checkbox"/>
Physical examination	
Body condition score less than 4 or greater than 5 (on 9-pt scale)	<input type="checkbox"/>
Muscle condition score: Mild, moderate, or severe muscle wasting	<input type="checkbox"/>
Unexplained weight change	<input type="checkbox"/>
Dental abnormalities or disease	<input type="checkbox"/>
Poor skin or hair coat	<input type="checkbox"/>
New medical conditions / disease	<input type="checkbox"/>

NO CHECKED ITEM(S) ON THIS PAGE? The Nutritional Assessment is complete
CHECKED ITEM(S) ON THIS PAGE? Continue on the next page



Extended evaluation checklist

Changes in food intake or behavior

- a. Amount eaten: increased decreased
b. Chewing: normal abnormal
c. Swallowing: normal abnormal
d. Nausea: yes no
e. Vomiting: yes no
f. Regurgitation: yes no

Condition of the integument

- a. Easily-plucked hair: yes no
b. Thin skin: yes no
c. Dry or scaly skin: yes no

Abnormalities in serum chemistry profile

- a. Glucose: low normal high
b. Albumin: low normal high
c. Total protein: low normal high
d. Electrolytes:
low _____
high _____
e. Urea: low normal high
f. Creatinine: low normal high
g. Total T4: low normal high

Abnormalities in complete blood count

- a. Anemia: yes no
b. Lymphopenia: yes no

Other _____

Abnormalities on fecal flotation / smear / culture:

Abnormalities on urinalysis:

Abnormalities on other diagnostic tests:

Provide the following recommendation(s):

Change in the caloric intake recommended? No Yes If yes, calculate:

Current caloric intake** _____ kcal or kJ/day

**Refer to information obtained from the diet history form.

Recommended caloric intake*** _____ kcal or kJ/day

*** Refer to the calorie requirement form.

Change in the diet recommended? No Yes If yes, describe:

New diet recommended _____

Change in the feeding management recommended? No Yes If yes, describe:

Amount per serving _____ cups _____ cans _____ grams

Number of servings per day _____

Treat(s) (if applicable); amount(s) and number(s) per day _____

Be sure to specifically discuss **table foods**, **supplements**, and **medication administration** with the owner.

Change of environmental factors recommended? (i.e., issues with multiple pets, other food providers and sources, extent of enrichment, activity of pet, environmental stressors)

No

Yes Describe: _____

Recommendations for monitoring given to the client?

(i.e., BW, BCS, MCS, food intake, appetite, gastrointestinal clinical signs, activity, overall appearance)

No

Yes If yes, please describe: _____

Did client purchase the recommended food? No Yes

Educational information or tools dispensed? No Yes