Nutrition Solutions

Susan Miller, BASc, MEd, Registered Dietitian / Health Educator

GETTING TO KNOW YOU…

Please complete the following questions, which will help me to get to know you better.
All information contained in this document is strictly confidential.

Name: _____Today's Date: _____
Address: _____Postal Code: _____
Email: _____ How did you hear about us? _____
Phone # (Res): _____ Phone # (Bus): _____ Phone # (Cell): _____
Date of birth: _____ Age: _____ Gender: Male / Female Body Frame: Small Medium Large
Family Doctor: _____ Reason for Visit: _____
Occupation/ or student: _____ Do you work shifts or travel? Y __ N __ Frequency: _____
Do you have children/ siblings? Y ___ N ___ If yes, number ___ and ages? _____

MEDICAL & WEIGHT HISTORY:

Are you presently under the care of a physician? Y __ N__ Date of last physical examination _____
Present Height: ____ in/ cm Present Weight: _____ lb/ kg Usual weight: ____lb/ kg
Highest Weight: ____lb/ kg Lowest Weight: ____ lb/ kg Desired weight: ____ lb/ kg
Do you use a scale to weigh yourself? Y__ N___ How often? _____ Stress Level? Low Med High
* BMI: ___ * Waist circumference: ___ inches Males: > 40 in Females: > 35 in; * Hip circumference: ___ inches;
* Hip to Waist Ratio. *We can calculate BMI, WC, MW and WC: HC ratio together
Do you have or have you had any of the following? Please check √

Weight Challenges __	Diabetes __	Hemorrhoids __	High blood pressure __
Disordered Eating __	Low blood sugar __	Chron's Disease__	Low blood pressure __
Anorexia __ Bulimia __	High blood sugar __	Colitis__	Fainting spells __
Depression __	Hyperthyroid __	Gas__ Bloating __	Stroke __
Mental Health Challenges__	Hypothyroid __	Heartburn__	High blood cholesterol __
Addictions ___	Osteoporosis __	Gastro-esophageal reflux__	High triglycerides __
Hepatitis/Jaundice __	Cancer __	Irritable Bowel Syndrome__	Are you Pregnant? Y _ N _
Arthritis __	Constipation __	Lactose Intolerance __	Nursing a baby? __ Y _ N _
Asthma ___	Diarrhea __	Celiac Disease __	# of months __

Are there any other medical conditions/ or surgeries that I should be aware of? _____
_____

Are you presently taking any prescriptions or non prescription medications or supplements (vitamins, minerals, protein powders or meal replacements?) Y __ N __ If yes, which ones? * Please bring bottles or containers to our session

Medication Name	Dosage	Vitamin/Mineral Supplement Name	Dosage

Have you taken prolonged medications in the past? Y _ N_ Name: _____
Side effects to medications? _____
Last blood test date and results:

Labwork:	Fasting Blood Sugar	HbA1c	Chol	LDL	HDL	Ratio Total Cholesterol: HDL	Triglycerides
Your lab values							
Normal ranges	4.0 –7.0 mmol/L	<7 %	< 5.2 mmol/L VLDL <1.0 mmol/L	< 3.5 mmol/L *Ideally, < 2.0 mmol/L for those at high risk	>1.0 mmol/L > 1.3 mmol/L	< 5.0 mmol/L *Ideally < 4.0 mmol/L	< 1.7 mmol/ L

Do you have any food allergies, food intolerances or food aversions? Y __ N __ If yes, to which foods:
_____
_____

Family Medical History: Father: _____ Mother: _____
Siblings: _____

Do you have complaints about the following?
___ Difficulty eating ___ Difficulty Chewing ___ Difficulty Swallowing ___ Nausea ___ Vomiting
___ Lack of appetite ___ Large Appetite
Other: _____
In the past 6 months, have you gained or lost more than 10 lb.? Y __ N __ If yes, please comment (pregnancy, illnesses, changes and in what time frame?): _____
Have you ever been counselled on a diet before? Y ___ N ___ If yes, please explain type, when and by whom:
_____
The weight you feel most comfortable at is? _____

LIFESTYLE / ACTIVITY HABITS:
Do you Smoke? Y_ N _ If yes, amount: _____Quit/ Decrease?_____
Do you use Alcohol? Y_ N _ If yes, amount per day/ per week? _____
Do you drink coffee? Y_ N _ If yes, how many cups / day? _____ Type: Regular ? ___Decaf?___
Do you drink tea? Y _ N _ If yes, how many cups / day? _____
Do you drink milk? Y _ N _ If yes, how many cups / day? _____
Do you drink water Y _ N _ If yes, how many cups / day? _____
Which foods do you particularly like?_____ dislike?_____
Do your eating habits change when you are under stress? Y_ N _ If yes, how? _____
Comments: _____
Do you avoid foods for religious / ethical / cultural reasons? _____
Hobbies: _____

Current Physical Activity

Day	Activity / Activities)	Duration
Sunday		
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		
Saturday		

How much time do you spend on each of the following activities each day? (Total in 24 hours)
___ Hr. Sleeping, resting or reclining
___ Hr. Very Light: Seated and standing, driving, computer, lab work, cooking, sewing/ ironing, playing games/ cards or a musical instrument
___ Hr. Light: Walking 2.5 – 3 m/h (4 – 4.8km/h), garage work, electrical/ carpentry, restaurant, house cleaning, child care, golf, sailing, table tennis
___ Hr. Moderate: 3.5 – 4 m/h (5.6 – 6.4 km/h) running, cycling, skiing, tennis, dancing, weight training, gardening, carrying loads
___ Hr. Heavy: > 4.5 m/h (7.2 km/h) running, walking up a hill with a load, aerobics, soccer, basketball, football and heavy lifting

Office Policy: (ALL CLIENTS must read)
Please help us to maintain the operation of our office on sound principles so that we may assure you and other clients of uninterrupted service. Once you have made an appointment this time is reserved for you, therefore at least 24 hours NOTICE must be given if cancellation is absolutely necessary – Call 604-506-6432; otherwise a $ 115.00 fee will be charged. Services are paid for at each visit. However, in certain circumstances arrangements for payment may be made with the dietitian. Regarding insurance: All professional services are CHARGED DIRECTLY TO THE CLIENT. We will prepare any necessary forms or reports to help you collect your benefits from insurance companies.
I understand that all information will be kept strictly confidential.
Client's Signature: _____ Date: _____

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Three Day Food Record

Name: _____ Date: _____

- Please make three copies of this page and complete as much information as possible. Be sure you include two week days/ working days/ or school days and one weekend day in your food record.

A nutritional assessment will be completed and a computerized nutritional analysis can be completed on this food record upon request.

Time	Describe the Food or Drink Taken	Amount/ Measure	Activity/ Exercise	How you Felt? Relaxed/ Sleepy/ Other
7:30 am	Example: Breakfast Orange juice Tea w/ 1% milk Whole wheat toast / Margarine (Becel)	 1/ 2 cup 6 oz. / 2 oz. 2 sl./ 2 tsp.	No Activity	Relaxed
	Breakfast			
	Mid Morning Snack			
	Lunch			
	Mid- Afternoon Snack			
	Supper/ Dinner			
	Evening Snack			

Vitamin / Mineral Supplement: _____

_____

_____

Other Supplements / Meal Replacements: _____

_____

_____

_____

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