SOUTHCENTRE
HEALTH & WELLNESS

Nutrition Consulting Assessment Form

Name:_____ Date of Birth_____

Address:_____

Phone number (Home)_____(Cell) _____

Email address:_____

Alberta Health Care #_____ Marital Status_____

How would you like to receive your appointment reminders: ___Email ___Text Message*

*CELL PHONE PROVIDER (required for TEXT reminder) **CIRCLE:** Bell/ Telus/ Fido/ Koodo/ Virgin/ Rogers/ PC Mobile

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

_____

_____

_____

_____

Have you seen a registered dietitian in the past? ___Yes ___No
If yes, was it helpful? Why or why not?

_____

_____

_____

_____

Do you have any medical conditions?

_____

_____

_____

Ph: 403.271.1081 | **Fax:** 403.271.4913

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Do you have any concerns with your current weight or shape? ___Yes ____No
If yes, what are your concerns?

_____

_____

_____

_____

Do you have any concerns with your eating habits? ___Yes ___No
If yes, what are your concerns?

_____

_____

_____

_____

List all the diets you have tried including commercial diet programs, diets written about in books, and those that you have developed yourself and indicate your age at the time. Give a brief description of each diet.

Diet or program Age Brief description

_____

_____

_____

_____

_____

Are there any foods you avoid currently? ___ Yes ___No If yes, please list below:

_____ For what reason? _____

_____ For what reason? _____

_____ For what reason? _____

_____ For what reason? _____

_____ For what reason? _____

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Food Preference

Allergies/Intolerance		
Food Like		
Food Dislikes		
Food Groups Avoided		Why?

How much alcohol do you drink in one week? _____

How many cups of caffeine-containing beverages do you drink daily? _____

Do you currently smoke? ___Yes___No

If yes, how many cigarettes do you smoke per day?_____

If no, have you ever smoked?____Yes____No If yes, when did you quit?_____

On average, how many hours of sleep do you get per night?

Weeknights _____ Weekends_____

Do you take any vitamin, nutritional, or herbal supplements? ___Yes ____No

If yes, please list each supplement and dose:

_____

_____

Are you currently taking any medications?

_____

_____

Do you skip meals? ___Yes___No

If yes, which meals do you skip and how often?

_____

_____

_____

The nutrition/eating habits that are most challenging for me:

_____

_____

The nutrition/eating habits that I am most pleased with:

_____

_____

Within your household, who does most of the cooking? _____

Within your household, who does most of the grocery shopping?

_____

Do you read nutrition labels? ___Yes ___No If yes, what do you look for?

_____

_____

How many times per week do you eat at restaurants? _____

How many times per week do you eat at fast food restaurants?_____

Digestive History

Please indicate how frequently you experience the following:

Symptom	Frequency		
Heartburn	Rarely	Sometimes	Often
Gas	Rarely	Sometimes	Often
Bloating	Rarely	Sometimes	Often
Stomach Pain	Rarely	Sometimes	Often
Nausea/Vomiting	Rarely	Sometimes	Often
Diarrhea	Rarely	Sometimes	Often
Constipation	Rarely	Sometimes	Often

Do you associate any digestive symptoms with eating certain foods? Yes____No____
Please explain:_____

_____

Weight History

Height:_____

Current weight:_____

Weight 2 months ago:_____ _____

Weight 6 months ago:_____

Weight 1 year ago:_____

Highest weight as an adult:_____ Age:_____

Lowest weight as an adult:_____ Age:_____

Please describe your exercise routine and/or amount of physical activity (type, frequency, time).

_____

_____

_____

_____

_____

_____

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Food Record

Please bring this form with you to your first follow-up appointment

Food Record Instructions

Keep track of everything you eat and drink for 2 weekdays (Monday – Friday) and 1 weekend day (Saturday/Sunday). Record your food and drink for a total of 3 days.

This food record will help you and the dietitian develop an awareness of your eating habits in order to formulate individualized nutrition goals. Follow the instructions below to complete your food record.

1. **Do not change** your eating habits on the days you are recording your food. The purpose of the food record is to identify your ***typical*** eating patterns.

2. Be honest! The dietitian will not judge you based on your food choices, but she needs accurate information to best provide recommendations.

3. Write down **EVERYTHING** including beverages.

4. **Be specific.** Don't forget condiments such as mayonnaise, butter, cheese on your sandwich, etc. Measure or estimate portions as accurately as possible.

5. Record your food right away! Don't rely on your memory at the end of the day. Keep a small notebook with you if needed and copy your intake to your log at the end of the day.

6. Use the following sample food record as a guide:

Day & Date	Time	Food & Drink	Specific amount / Portion Size	Where/Activity
Tuesday 1/1/2013	*1pm*	*Turkey wrap* *Baked Lays* *Sprite* *Diet Sprite*	*1 whole wheat tortilla, 3 oz. turkey breast, 1 slice American cheese, 1 tsp. honey mustard, 1 slice lettuce* *Make a good estimate of the amount of the particular food/beverage or snack and write the serving sizes. Indicate the volume measure (3/4 cup), size (2" x 1" x 1"), the weight (6 oz) or the number of items or pieces (12) of the type of food consumed. When possible you may want to use measuring utensils. A good source for estimating portion sizes is National Heart, Lung and Blood Institute's pocket guide to estimating portion sizes available at - http://hp2010.nhlbihin.net/portion/servingcard7.pdf*	*Indicate where you had consumed the meal/snack – restaurant, at home, in car, at school/work. Also write down any activities you did such as watching TV, driving, studying, working at the computer etc.*

Name _____ **Food Record Day 1**

Day & Date	Time	Food & Drink	Specific amount / Portion Size	Where/Activity

Activity - Estimate the number of hours spent this day at each activity level:

1. Sleeping/resting_____
2. Sitting_____
3. Light activity_____
4. Active/Sport/Training (Describe in detail):

_____

_____

Name _____ **Food Record Day 2**

Day & Date	Time	Food & Drink	Specific amount / Portion Size	Where/Activity

Activity - Estimate the number of hours spent this day at each activity level:

1. Sleeping/resting_____
2. Sitting_____
3. Light activity_____
4. Active/Sport/Training (Describe in detail):

_____

_____

Name _____ **Food Record Day 3**

Day & Date	Time	Food & Drink	Specific amount / Portion Size	Where/Activity

Activity - Estimate the number of hours spent this day at each activity level:

1. Sleeping/resting_____
2. Sitting_____
3. Light activity_____
4. Active/Sport/Training (Describe in detail):

_____

_____