

Phone: (403) 389-3284

E-mail: sarah@nutrioconsulting.ca

Web: www.nutrioconsulting.ca

Nutrition & Health History Form

*Please complete this questionnaire and have it with you for your initial assessment.
All information will be kept strictly confidential.*

PERSONAL INFORMATION:

Name: _____ Date: _____

Address: _____ Postal Code: _____

Telephone: (H) _____ (B) _____

Occupation: _____ Employer: _____

Date of Birth: _____ Age: _____

Marital Status: _____ Referred By: _____

Physician's Name / Address / Tel. No. _____

May he / she be notified of your visit(s): yes no

Do you have any children – if yes, how many _____

Present Weight: _____ Height _____ Goal weight _____

MEDICAL BACKGROUND:

Are there any medical conditions that the Dietitian should be aware of *eg. Diabetes, cardiovascular disease, osteoporosis, autoimmune disease etc.*: _____

Family History (same as above): _____

Are you taking any medications presently? Yes No

If yes, what? _____

Do you have any food sensitivities or food allergies? Yes No

If yes, what? _____

Do you have any Digestive issues? Please explain: _____

Are you taking any vitamin / mineral / herbal supplements? Yes No

If yes, what? _____

Do you use any other health services? Yes No

If yes, what? _____

Are you pregnant or breastfeeding? If "yes" please indicate what month of pregnancy you are in or how long you have been breastfeeding for: _____

LIFESTYLE HABITS:

Do you drink coffee? Yes No If yes, how many cups / day? _____

Do you drink tea? Yes No If yes, how many cups / day? _____

Do you drink milk or soy milk? Yes No _____ If yes, how many cups / day?

Do you drink water Yes No If yes, how many cups / day? _____

Which foods do you particularly like? _____

Which foods do you particularly dislike? _____

Which foods do you avoid for religious / ethical / cultural reasons? _____

How many times a week do you eat out? _____

Where do you typically go (Restaurants, fast food, cafeterias, take-out)? _____

For what meal do you typically eat out (Breakfast, Lunch, Dinner)? _____

Who does the grocery shopping in your household? _____

Who does the food preparation and cooking in your household? _____

Do you enjoy cooking? _____

Describe your level of cooking from 1 to 10: 1 being do not know how to cook; 10 being excellent cooking skills:

How many hours of sleep do you typically get? _____

How much alcohol do you drink / week? _____

Do you smoke? Yes No _____ If yes, how much? _____

What physical activity do you do? _____

How often do you exercise? _____

Goals:

Please list/explain your nutrition goals: _____

Nutrition Intake Form

Instructions for completing Nutrition Intake Form;

- Please write out 3-5 days of your food intake as accurately as possible.
- Write the items that you ate for each meal; include brand names if needed. Leave meal times blank if there was no item eaten.
- Write the amounts and times of the day that you ate, eg. 3 oz (deck of cards) boneless, skinless chicken breast, 1 cup, 8 oz or 250 mls. 2% milk
- Include water, alcohol, coffee, margarine, butter, spices, and condiments if applicable.
- Specify method at which the food was cooked, eg. Fried in 2 tbsp olive oil, steamed with water, baked in oven with no oil.
- In the OTHER section, please write out where you ate, or how you felt.
- Please include at least one weekend day.
- Please ensure this is completed and ready for the RD at the initial assessment or sent back to the Nutritionist at least 2 days prior to the initial assessment. If faxing, please let Sarah know (by phone or e-mail) the date and time that you will be sending the fax. Fax or email to;

Day One Circle one of the following: *I ate more than usual* *the same as usual* *Less than usual*

Meal	Time of Day	Items Eaten	Amounts	Other
Breakfast				
Snack				
Lunch				
Snack				
Dinner				
Snack				

Day Two Circle one of the following: *I ate more than usual* *the same as usual* *Less than usual*

Meal	Time of Day	Items Eaten	Amounts	Other
Breakfast				
Snack				
Lunch				
Snack				
Dinner				
Snack				

Day Three Circle one of the following: *I ate more than usual* *the same as usual*
Less than usual

Meal	Time of Day	Items Eaten	Amounts	Other
Breakfast				
Snack				
Lunch				
Snack				
Dinner				
Snack				

Day Four Circle one of the following: *I ate more than usual* *the same as usual* *Less than usual*

Meal	Time of Day	Items Eaten	Amounts	Other
Breakfast				
Snack				
Lunch				
Snack				
Dinner				
Snack				

Day Five Circle one of the following: *I ate more than usual* *the same as usual* *Less than usual*

Meal	Time of Day	Items Eaten	Amounts	Other
Breakfast				
Snack				
Lunch				
Snack				
Dinner				
Snack				

Nutrio Consulting waiver and acknowledgment

I, _____ hereby grant permission for Sarah Remmer, RD of Nutrio Consulting to correspond with my physician(s) to obtain information relevant to my nutrition treatment and counselling. I acknowledge that any information so obtained will be held in strict confidence. I further acknowledge the information provided to me by Nutrio Consulting is designed to meet my personal dietary needs. It is NOT suitable for any other individuals and will not be transferred, copied or sold to another person.

In order to benefit from the treatment prescribed by Nutrio Consulting, I realize that it is important for me to inform either my physician or Sarah Remmer of any changes I make in the application of my diet. It is my responsibility to report any side effects or problems immediately and to make the necessary adjustments to my treatment plan with my physician and/ or Sarah Remmer. I will not hold my physician or Sarah Remmer responsible for any complications that result from my failure to comply with either of the above.

I have agreed to have my Registered Dietitian keep records of our visits and to file these in a secure and appropriate place. I agree to have the Registered Dietitian contact other Health care Professionals to benefit in my care and to share my personal information. This may be accomplished by letter, phone, fax, or email.

Cancellation policy:

Twenty-four (24) hours notice is needed to cancel/reschedule your appointment. This allows our office to seek a replacement. If 24 hours notice is not provided, a fee of \$25.00 will be charged to you.

Thank you for your cooperation and understanding.

Date: _____

Client's Signature: _____

Witness: _____