JCC REGISTERED DIETITIAN INQUIRY

Date ________________

Name ____ Age ________________

Address ____

City ____ Zip ____________

Email ____

Phone (1) ______________________________ (2) ______________________________

NUTRITION ASSESSMENT

What is your reason for seeing a dietitian? ____________________________________

____

____

List any dietary restrictions ____

____

____

List any goals you hope to achieve as a result of nutrition counseling ____________

____

____

Height ____________________ Current Weight ____________________

What was your highest adult weight? __________ What was your lowest adult weight? __________

How many times per week do you eat out the following meals?
Breakfast _______ Lunch __________ Dinner __________

How many times per week do you cook? _______

Are you currently engaged in a regular exercise program? Yes __________ No ____________

MEDICAL HISTORY (check all that apply)

_____Recent illness, hospitalization or surgical procedure
_____Heart attack, coronary bypass, cardiac surgery, stroke
_____Abnormal blood lipids (total cholesterol, HDL, LDL, triglycerides)
_____Family history of coronary or other atherosclerotic disease prior to age 55 male, 65 female
_____Diabetes Mellitus (type I, type II, or gestational)
_____High blood pressure
_____Drug or food allergies (if YES, please list specific allergies)______________________________
_____Smoking
_____Alcohol consumption
_____Physical inactivity
_____Other (explain below)

Please list any concerns or information that you would like to discuss that have been not been addressed above ____

____

____

Please list all medications and supplements you are currently taking _________________________

____

____

CONTRACT INFORMATION

1. Cancelling a session requires 24-hour notice or the client will be charged for a session.

2. All sessions must be used within six months from the date sessions are purchased.

____ ____________________
CLIENT SIGNATURE DATE