Stacie V. Ellis, PhD, RDN, LD

www.stacieellisrdn.com ● 469-708.6940 ● StacieEllisRDN@yahoo.com

**CONSENT FOR TREATMENT**

**AND AUTHORIZATION FOR USE OF PROTECTED HEALTH INFORMATION**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Applies for patients under 18)

I hereby consent to participating in nutrition counseling with Stacie Ellis, RDN, LD and understand that all information I provide is private, confidential, and protected by law. When necessary to coordinate my nutrition and healthcare my protected health information may be obtained from and/ or provided to my:

* Primary Care Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Other Doctor(Relationship): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Stacie Ellis PhD, RDN, LD is hereby released from legal responsibility or liability for the release of information authorized here in. I understand that I have the right to revoke this authorization in writing at any time by sending notification to Stacie Ellis PhD, RDN, LD. I understand that I have the right to (1) inspect or obtain a copy of the protected health information to be provided as permitted under federal and state law, and (2) refuse to sign this authorization. My signature indicates understanding and acceptance of the above policies.

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(If patient is under 18)

**HIPAA Acknowledgement**

By signing below I acknowledge that I received a copy of my rights as described in Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(If patient is under 18)

Insurance Policy

Stacie Ellis, PhD, RDN, LD does not currently accept insurance for her practice and client is responsible for all fees pertaining to appointments. Clients may choose to submit their invoice to insurance company in states allowed for the dietitian’s practice, including the state of Texas, Arizona, California, Colorado, and New Jersey. If the client desires to do so they must request an invoice with appropriate diagnostic codes that can submit for reimbursement if your insurance covers dietetic services.

I have read and understand Stacie Ellis, PhD, RDN, LD Insurance Policy.

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(If patient is under 18)

New Patient/Client Registration

Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of individual responsible for charges: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Phone (if different from client): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Client Information*:**

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: Home \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Work \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred contact method: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Number of People in Household: \_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referred by:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Reason:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Acceptance of Registration Information

I hereby accept the registration information written above as accurate and acknowledge this information will be used to guide the Registered Dietitian in preparing my personalized plan of care.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Signature of New Patient/Client Date*

Health Information

Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age: \_\_\_\_\_\_\_\_\_\_\_ Gender:

Height: \_\_\_\_\_\_\_\_ Current Weight: \_\_\_\_\_\_\_\_ Usual Weight: \_\_\_\_\_\_\_\_\_

Length of time at current weight: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Lowest weight at current height: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Highest weight at current height: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you satisfied with your current weight? Yes \_\_\_ No \_\_\_

What do you consider your “ideal” weight? \_\_\_\_\_\_\_\_\_\_\_\_

Do you gain or lose weight regularly? Yes \_\_\_ No \_\_\_

Briefly provide any additional information regarding your weight history here:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| ***Medical*** |
| Have you ever been diagnosed with any of the following? Check all that apply□ hypoglycemia □ disordered eating patterns (such as stress/emotional eating)□ hypertension (high blood pressure) □ pulmonary disorder (ex: COPD, asthma) □ heart disease □ osteoporosis /low bone mass □ arthritis □ severe acne □constipation □diarrhea□ anemia-specify □iron □ vitamin B12 □ vitamin B6 □ kidney disease-specify □acute □ chronic stage □1 □ 2 □ 3 □ 4 □been on dialysis □ eating disorder- specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_□ food intolerance- (ex. Lactose, gluten) specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_□ food allergies- specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_□ food sensitivities- specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ abnormal labs- if so specify which-  □ low vitamin D levels □low iron or ferritin level □ Low B12 □ low prealbumin, albumin, or CK □ low electrolytes (Mg, Ca, K, Na, CL) □ abnormal hormone levels- specify □high estrogen □ low estrogen □ high testosterone □ low testosterone □elevated cortisol □ low insulin □ high thyroid hormones □ low thyroid hormones  □ high cholesterol/ blood lipids- specify □ high LDL □low HDL □ High TG □ other abnormal labs \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_□ diabetes mellitus, pre-diabetes, gestational diabetes, please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_□ digestive problems, please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_□ thyroid problems, please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_□ diagnosed mental health conditions please specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_□ other conditions, please specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Body Fat % (optional) \_\_\_\_\_\_\_\_\_\_\_ Date measured: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Type measure (circle one)

DXA Skin fold Hydrostatic/underwater weighing

Ultrasound 3-D body scan InBody(bioelectrical impedance (BIA))

Scale with BIA BIA hand held Bod Pod

If you have a copy of your Body Fat measurement report, please attach a copy.

Do you smoke? Yes \_\_\_ No \_\_\_

 If yes, what do you smoke and how much per day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of last physical: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Do you have labs: Yes (please attach a copy) No

If you have no labs available, were their any labs that your doctor notified you in the past that were a concern? If so please specify in the above table.

Medications/supplements/ herbals: Please list any medications, supplements (vitamins, performance supplements, protein powders, protein bars, etc.) and herbals you are currently taking. Add additional pages if needed.

|  |  |  |
| --- | --- | --- |
| Medication/Supplement/herbal | Dosage | How often do you take? |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

|  |
| --- |
| Holistic Health: For the next section, respond by circling the appropriate response based off of how you personally feel you are doing with each one. Poor Average Excellent  |
| Psychological health (mental health) | □ | □ | □ |
| Emotional health (mood, happy, sad, angry, etc.) | □ | □ | □ |
| Spiritual health (religion, self-reflection, volunteering in community, meaning, etc.) | □ | □ | □ |
| Personal life (time for self, time with friends and family, hobbies, self-care, etc.) | □ | □ | □ |
| Professional (time for lunch, boundaries, not overworked, time off, support, fulfillment, etc.) | □ | □ | □ |
| School/college (workload, time management, academic success, etc.) | □ | □ | □ |

Feel free to further explain any answers here and any of its effects on your eating: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Exercise History:**

Which of the following primarily describes your work, school, or daily activity?

Sitting Standing Walking or other active motion Heavy labor (heavy lifting)

Do you currently exercise? Yes Yes, but not consistently No

If yes, please specify what kind of activity, how many minutes and how many days a week.

Activity: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long and how often: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you do resistance training, please specify your workout split. Include the number of exercises per session, number of reps and sets. Do you train heavy, moderate, or light weights? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is your goal with your workouts? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you new to exercising?\_\_\_\_\_\_\_\_\_\_\_ If no, how many years/months have you been exercising?\_\_\_\_\_\_\_\_\_\_\_

Are you working with a trainer? \_\_\_\_\_\_\_\_\_\_\_\_\_

**Sleep**

How many hours of sleep do you typically get a night? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have a set sleeping schedule? Yes No

What time do you normally go to bed at night? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What time do you normally wake up? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you nap during the day? Yes No

Other than mid to late afternoon, do you feel tired throughout the day? Yes No

**For Women only:**

Do you currently have a regular menstruation? Yes No

 If no, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 If yes, did you have a history of irregular menstruation Yes No

 If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Did you see a doctor to help resolve the issue? Yes No

 If yes, did the doctor prescribe birth control in order to regulate your cycle? Yes No

 If yes, are you currently using birth control to regulate your cycle. Yes No

Are you currently pregnant? Yes No

Are you currently nursing? Yes No

Diet and Eating Habits

Please indicate whether you have ever used any of these methods to control your body weight (check all that applies).

|  |  |  |
| --- | --- | --- |
| **Method** | **When did you do this** | **Length of time used** |
| □fasting |  |  |
| □skipping meals  Specify meals: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
| □ intermittent fasting  Specify eating window \_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
| □commercial weight loss programs Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
| □liquid supplements (ex: slim fast) Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
| □very low calorie diet (<1200 kcal/d) Calories consumed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
| □self- induced vomiting |  |  |
| □laxatives or diuretics |  |  |
| □diet pills or “fat-burning” supplements |  |  |
| □excessive exercise  Specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
| □low fat diet/ high carbohydrate diet |  |  |
| □high protein diet/ low carbohydrate diet |  |  |
| □ high fat diet such as keto, Atkins, Zone diet |  |  |
| □vegetarian/ vegan/pescatarian diet for the purpose of weight control Specify type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
| □nutritional counseling (ex: with a dietitian or nutritionist) |  |  |
| □ Calorie counting  Calories consumed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
| □ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |

Do you have any foods you do not eat for any reason? Yes \_\_\_ No \_\_\_

 If yes, please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are there any foods that you would find difficult NOT to eat? Yes \_\_\_ No \_\_\_

 If yes, please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been on any special diet? Yes \_\_\_ No \_\_\_

 If yes, what kind of diet(s)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 When? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Was there any component of the diet(s) that worked well? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you changed your eating habits or appetite in the last 6 months? Yes \_\_\_ No \_\_\_

 If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you feel you are an emotional eater? □ Yes □No

If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How much and what kinds of foods do you eat during these times? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How often does this occur? (Circle one)

 Daily 1 x a week 2-3x a week 4-6x a week 1x a month 2-3x a month Occasionally

Describe your present appetite. (Circle one)

 Very good Good Okay Poor Very Poor

How is most of the food you eat cooked?

 Boiled \_\_\_ Fried \_\_\_ Baked \_\_\_ Broiled \_\_\_ Grilled \_\_\_ Sauté \_\_\_

 Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who cooks the meals in your home? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How often do you have a home cooked meal (including leftovers)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you use salt during cooking? \_\_\_\_\_\_\_\_\_ At the table? \_\_\_\_\_\_\_\_\_\_\_\_

What type of milk do you drink?

 Skim 1% 2% Whole Buttermilk Flavored Milk

 Almond Milk Soymilk Rice Milk None – I don’t drink milk

 Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How often do you drink it? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What beverages do you normally drink during the day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How much do you drink a day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you drink beer, wine or any other alcohol? Yes \_\_\_ No \_\_\_

 If yes, what do you drink? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 How much and how often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How often do you get fast food during the week? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 List some of the fast food places you would go to and what you would order \_\_\_\_\_\_\_\_\_\_\_\_\_

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How often do you eat at a sit down restaurant during the week? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List some of the restaurants you would go to and what you would order \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Please describe how you normally eat on a typical day. Please specify the amount, brands, and types of food. Please include what time you normally eat as well:

Time Meal

Morning meal

 Mid-day meal

 Evening meal

 Snacks

Briefly describe what you hope to learn from this session: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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If there is anything else you would like to share, please feel free to comment.

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Food Diary (Recommended, but optional)

To help the RD get a better idea of your typical diet please complete this 3 day food diary and bring it to your appointment.

3 Day Food Diary Directions

Please record all food and drink, for 3 days, 2 weekdays and 1 day during the weekend. It is easiest to record correctly if recording is done directly after a meal or snack.

1. Describe the food accurately and give brand names if possible. For example: margarine (Blue Bonnet soft tub) 1 teaspoon levels with knife.

2. Please record any foods that state they are fortified with additional vitamin D or calcium.

3. State whether fruits and vegetables are fresh, canned (water pack, heavy or light syrup), cooked or frozen.

4. Record the amount of food eaten by using household measures such as cups, teaspoons, tablespoons, or weigh the food. For example: Whole milk ½ cup or 4 ounces (oz) 2% cottage cheese or 4 level tablespoons.

5. For meat every oz is about the size of a match box. 3 oz is about the size of a deck of cards. Keep in mind the bone takes up space. For example: Broiled pork chop with bone = 3 ounces, bone weight is 1 ounce, so total weight of pork chop is 2 ounces.

6. Describe sandwiches in detail.

For example: Bologna sandwich: 2 slices of whole wheat bread, 1 slice (1 ounce) bologna, 1 level tablespoon Kraft Mayonnaise (lite or regular), 1 lettuce leaf, 1 slice (1 ounce )Processed cheese (Kraft)

7. Be sure to record amounts of additional foods served with cereals or desserts, etc.

For example: Cereal: ½ cup Rice Krispies (Kellogg’s), ¼ cup milk 2%, 2 level tablespoons Brown Sugar

8. Include how the food is prepared especially for meats, fish, poultry, eggs, and vegetables. Methods of preparation include boiling, roasting, baking, broiling, frying or steaming. When frying, be sure to mention the type of fat or oil used.

9. If eating out, describe food item well. Please record the name of popular fast food restaurants as we have nutrition information for all foods

10. Please include any vitamins and minerals you consume.



http://remakemyplate.com/resources-tips-and-tools/size-it-up-portion-sizes/

3 Day Food Diary

Date: Example

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Time | Food/drink eaten | How hungry before meal (1-5, 1=very hungry, 2=hungry, 3=neutral, 4=satisfied, 5= full) | Mood before meal | How hungry after meal(1-5, 1=very hungry, 2=hungry, 3=neutral, 4=satisfied, 5= full) | Mood after meal |
| *8:15am* | *1 cup cereal, 1 cup 1% milk, 1 large banana, 1 cup coffee with 1 tsp sugar* | *1* | *tired* | *4* | *Slightly awake* |
| *10:30* | *Granola bar* | *3* | *bored* | *4* | *Slightly happy* |
| *12:30* | *Sandwich- 2 slice whole wheat bread, slice of American cheese, 2oz of lean ham deli meat, lettuce, tomato, 2 tbsp mayo**1 oz Doritos chips**1 small cookie**½ cup apple sauce**8 oz water* | *2* | *annoyed* | *5* | *happy* |
| *2:00* | *1 fun size snickers bar, 8 oz water* | *3* | *happy* | *3* | *happy* |
| *5:00* | *16 oz Gatorade* | *3* | *Bored* | *4* | *Bored* |
| *6:00* | *3 oz chicken breast, 1 cup mash potatoes, 1 tsp butter, ½ cup canned green beans, ½ cup corn, 1 cup apple juice* | *2* | *tired* | *5* | *neutral* |
| *7:00* | *6oz cup of flavored Greek yogurt* | *3* | *Happy* | *4* | *happy* |
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| Time | Physical Activity | How long | Intensity |  |
| *2:30* | *Ballet- Advance level* | *1hr 30 min* | *low* |
| *4:30* | *Gym- weights lower body and back* | *45 min* | *high* |

3 Day Food Diary

Date:

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| Time | Food/drink eaten | How hungry before meal | Mood before meal | How hungry after meal | Mood after meal |
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| Time | Physical Activity | How long | Intensity |  |
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3 Day Food Diary

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| Time | Food/drink eaten | How hungry before meal | Mood before meal | How hungry after meal | Mood after meal |
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3 Day Food Diary

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| Time | Food/drink eaten | How hungry before meal | Mood before meal | How hungry after meal | Mood after meal |
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