WELCOME!

This is to confirm ______________________________________’s
Patient’s Name

appointment with: **Dana Snook, LDN, CDE, CIC**
Natalie Navarre, RD, LDN
Lisa James, MS, RD

on __________________, ___________________ at __________________.
Day Date Time

Your appointment is scheduled for our office at:

4829 Street Road, Suite 100	**31 Cambridge Lane Suite A**	**1501 N Main Street, Suite 230**
Trevose, PA 19053	**Newtown, PA 18940**	**Warrington, PA 18976**

Please do not hesitate to call us should you require directions to our office. If you prefer, you can print directions from our website: www.MKPEDS.com.

Prior to your visit, please review and complete the enclosed information and bring it with you to your appointment. Feel free to call our office at 215-968-5151, should you have any questions prior to your visit.

We look forward to meeting you!

MK*Plus*
Nutrition Counseling

Office Policy Information

Payment:
Payment is expected at the time of your appointment. Checks are to be made payable to MK*Plus.*

Cancellation Policy:
Individual appointments are scheduled for a specific time. You will be charged for missed individual appointments unless the office is notified of cancellation at least 24 hours in advance, or in cases of emergency.

Confidentiality:
All information disclosed within sessions is confidential as outlined in the HIPAA notice of Privacy Practices.

Medical Insurance:
Medical insurance companies may or may not offer coverage for medical nutrition therapy. Carefully investigate the type of coverage you have. It is your responsibility to pay for your visit and to have your insurance company reimburse you if applicable. You will be provided with a receipt that you can submit to your insurance company for reimbursement.

I have read and understand the above information.

Signature of responsible party: ______________________________

Date: ____________________

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Signature of responsible party: ____

Date: ______________________________

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Nutrition History Questionnaire and Assessment (Adult)

General Information:

Client's Name: ____ Today's Date: ______________

Address:____

Phone: ______________________________ Phone#2:________________________________

Email: ________________________________ Preferred language: _____ ________________

Age: ______________________ Date of Birth: _______________ Gender: __________________

Marital Status: ___ Single ___ Married ___Divorced ___ Separated ___ Widowed

Occupation (what are you doing in life and how do you feel about it?):

____

____

How did you get referred to our office? ____

Emergency Contact: _________________________ Phone: ________________________________

Briefly explain your reason for seeing a Dietitian today:

____

____

____

____

Medical History:

Primary Care Provider: __________________________________ Phone: _______________________

Address:____

Height: ____' ____" Weight: _____ lbs.

List any other health care professionals you see on a regular basis (cardiologist, endocrinologist, therapist, etc.):

____

____

Indicate below if you have/had any of the following conditions: (Check all that apply)

_____ Allergies

_____ Cancer

_____ Diabetes

_____ Eating disorder

_____ Gastrointestinal Disease

_____ Heart disease

_____ High blood pressure

_____ High cholesterol

_____ Kidney disease

_____ Obesity

_____ Osteoporosis

_____ Anxiety, Depression, OCD, PTSD

_____ Thyroid disease

_____ Other: _____________

List below the type and dosage of any medications, supplements, vitamins or herbs you are currently taking.

___________________________________ ____________________________________
___________________________________ ____________________________________
___________________________________ ____________________________________

Family History:

Please tell me about your family and family dynamics:

What was eating and food like in your house growing up? Was there concern about weight or dieting?

Does anyone in your family have a history of chronic illnesses (eating disorder, diabetes, heart disease, high cholesterol, high blood pressure, thyroid condition, PCOS)?

Eating / Lifestyle Habits:

Do you enjoy eating? ___ Yes ___ No Do you skip meals? ___ Yes ___ No
If yes, which ones do you skip and why?
____
____
How many meals do you eat per day? _______ How many snacks do you eat per day? _________
Where do you eat your meals and snacks? ____
Who does the cooking/ food shopping? ____
How many meals per week do you eat from or at a restaurant? ___________
What restaurant or take out to you normally eat? _______________________________________
____
Do you enjoy fruits and vegetables? ____ Yes ____ No
Please list any foods you dislike:
____
____

List any food allergies/sensitivities you have as well as any foods you avoid for religious and/or personal reasons:

____

Do you eat and multitask (i.e. driving, working, computer, tv)? ___ Yes ___ No

Do you feel as if you are a fast, slow or an averaged paced eater? ___ Yes ___ No

Do you read nutrition labels? ___ Yes ___ No

If yes, what do you look for? ____

Do you smoke? ___ Yes ___ No

If yes, how many cigarettes/cigars per day? _____

Do you drink alcohol? ___ Yes ___ No

If yes, how often do you consume alcohol? (Circle the best answer)

Daily *A few times per week* *A few times per month*

If yes, about how many alcoholic drinks do you consume per week? _____

How many times a week do you consume soda or sweetened beverages (i.e., sports drinks, lemonade, iced tea etc.)?

____

Approximately how many ounces/cups of water do you drink a day? _____

Do you feel as if you overeat? ___ Yes ___ No

If yes, how often and why? ____

Are there any foods you feel "out of control" eating? _____________________________________

Do you ever vomit after eating? ___ Yes ___ No

Do you feel as if you under eat? ___ Yes ___No

If yes, how often and why? ____

____

Do you experience any of the following if you have not eaten in a while? (Check any that apply)

___ Irritability ___ Lightheadedness ___ Weakness ___Headache ___Other: ___________

Have you tried to make changes to your diet in the past? ___ Yes ___ No

What obstacles have you faced, or might you face, when trying to improve your diet? (Check all that apply)

___ Emotional stress

___ Frequent travel

___ Lack of money to buy nutritious foods

___ Lack of time to prepare healthy meals

___ Work schedule/requirements

___ Lack of support from relatives/friends/ coworkers

___ Other: ______________________________

___ None

Rate your energy level. (Circle the best answer)

Excellent Good Fair Poor

How would you rate your quality of sleep? (Circle the best answer)

Excellent Good Fair Poor

How many hours of sleep do you get per night? _____

Do you often wake up at night and eat? ___ Yes ___ No

How many days per week do you exercise? ________________

How long does each session last? ____

Describe what type of exercise you do.

____

Do you enjoy exercising? ____Yes ____ No ____ Sometimes

Weight Questionnaire:

(If this section feels uncomfortable, please leave blank and we can discuss together)

How do you feel about the way you look at this weight? (Circle one)

Extremely unhappy Unhappy Neutral Happy Very happy

At what age did weight gain start? ___________________

Highest Adult Weight? ______________ Age: ____________

Lowest Adult Weight? _______________ Age:_____________

Do you weight yourself and how often?

____

How often do you feel your weight affects your daily activities? (Circle one)

Always Often Rarely Never

What weight loss/fitness/lifestyle programs have you tried in the past? (Check all that apply)

____ Diet on your own ____ LA Weight Loss _____ Weight Watchers

____ Exercise at home ____ Jenny Craig _____ NutriSystem

____ Doctor run weight loss ____ Gym/Personal Trainer _____ Bariatric Surgery

____ RD or nutritionist Other: _______________________________________

Include below anything else you would feel is important.

____

____

____

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Instructions for Completing a Food Diary

1. Write down everything you eat or drink for two days. Remember to include all of those "tastes" or food you may eat which is not a meal.
2. Measure and record the amounts of food served in common portion sizes such as cups, teaspoons, tablespoons, or describe size. (e.g. 1 large banana – 8" long)
3. Indicate how the food was prepared: fried, steamed, baked, raw, etc.
4. Be as specific as possible. Instead of "turkey sandwich," say, "turkey sandwich made with 2 slices Wonder Light whole wheat bread, 4 slices of Sara Lee deli select turkey breast, 1 tablespoon Hellman's reduced fat mayonnaise, and two 4-inch pieces of romaine lettuce."
5. List brand names of all food products, for example, oatmeal might be "Quick Quaker Oats."
6. Be sure to measure and record all those little extras: gravies, salad dressings, taco sauce, pickles, jelly, sugar, ketchup, margarine, etc. Indicate the amounts.
7. Include recipes for any unusual items you prepared at home.

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Food Journal

Name: ____ Date: ________________________

Time & Place	Food Eaten	Amount

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Food Journal

Name: ______________________________ Date: ______________________

Time & Place	Food Eaten	Amount

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Food Journal

Name: ______________________________ Date: ______________________

Time & Place	Food Eaten	Amount

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Food Journal

Name: ______________________________ Date: ____________________

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