DECO Nutrition Counseling Paperwork

Patient Name: _____DOB: _____
Phone #:_____ **email address:** _____
Occupation: _____

Have you seen a dietitian before? □ Yes □ No

Reason for today's visit:
_____
_____

Height: _____ **Weight:** _____ **Usual Weight:** _____ **Desired Weight:** _____

Weight history:
_____
_____
_____

Personal Medical History (any current or past health conditions that you suffer/ed from):
_____
_____

Family Medical History (any medical problems your immediate family suffers/ed from):
_____
_____
_____

Are you currently taking any medications, vitamins or supplements? Please list:
_____

Are you satisfied with your weight and/or body size?

□ **Very Unsatisfied** □ **Mostly Unsatisfied** □ **Neutral** □ **Mostly Satisfied** □ **Very Satisfied**

How would you describe your appetite? □ **Poor** □ **Fair** □ **Good** □ **Great**

What is your main question or concern related to your diet? _____
_____
_____

Have you ever been taught carbohydrate counting? □ **Yes** □ **No**

Do you have any food allergies or sensitivities? □ No □ Yes (describe): _____

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Do you follow a special diet?

□ Diabetic □ Vegan □ Gluten Free □ Low Salt □ Vegetarian □ Paleo □ None □ Other

_____

Are you currently or regularly experiencing symptoms of:

□ Nausea □ Vomiting □ Diarrhea □ Constipation □ Gas □ Reflux

Please list foods that you like most: _____

_____

Please list any foods that you do not like: _____

_____

How often do you exercise?

□ Rarely □ Occasionally □ 1-2 times per week

□ 3-4 times per week □ 5 or more times per week

Type of exercise you do _____

How many meals out per week? _____ □Fast Food □Sit Down □Take Out

Are these meals with family or friends? □ Yes □ No

Are you presently undergoing any major lifestyle changes? (Marriage, divorce, job change, death of someone important to you?)

_____

_____

Please describe a typical day's food intake.

Breakfast	
Lunch	
Dinner	
Snacks	
Fluid	