Nancy Taylor, MS, RD
Registered Dietitian
Nutrition Consultant

135 Eagles Nest Drive Suite J1
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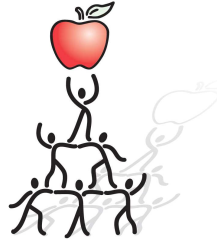

NuCommunity, LLC

Supporting your success to health through nutrition and wellness services!

nucommunity@bellsouth.net

CLIENT REGISTRATION INFORMATION

Name: ____

Home Address: ____

City ____________________________**State** ______________**Zip** _________________

Date of Birth: _______/________/__________ **Social Security Number:** ______-_____-__________

Telephone Number: **Home (_______)**_________________ **Work (_______)**_____________________

Cell (_______)_________________ **E-mail address** ____________________________

Occupation: ____

Employer: ____

Name of Person Responsible for Bill: ____

Insurance Company _______________________________**Plan** ______________________________________

Referred by: **(Doctor)** ___________________________________**(Phone#)**______________________

Reason for Referral: ____

____

Doctor's Address: ____

City _______________________________**State** ________________**Zip** ____________

How did you hear about us? _____ **Your Physician** _____ **Yellow Pages** _____ **Internet**

_____ **Friend/Family/Co-Worker** _____ **Other (Please describe)** ____________________________________

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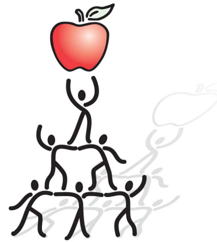

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INITIAL VISIT/MEDICAL & NUTRITION HISTORY

Client Name: ____________________________________ **Date of Birth:** ___/___/___

Reason for seeking nutrition counseling: ____________________________________

____

Current Medical History (Check any that apply:

	Personal History	Family History
Hyperlipidemia (High Cholesterol, High Triglycerides, etc.)	_____	_____
Heart Disease	_____	_____
High Blood Pressure	_____	_____
Diabetes	_____	_____
Kidney Disease	_____	_____
Frequent episodes of diarrhea and/or constipation	_____	_____

Any Other Medical History (Please list whether personal or family): _____________

____

List Medications and Dosage you are currently taking: ________________________

____

____

List Vitamins/Minerals/Herbs and Dosage you are currently taking: _____________

____

____

Lab Values (Please list if you know them):

Hemoglobin A1c _____ **Blood sugar (Fasting)** _____ **Blood Sugar (Non-fasting)** _____

Total Cholesterol _____ **HDL Cholesterol** _____ **LDL Cholesterol** _____ **Triglycerides** _____

WEIGHT HISTORY:

Height __________ Weight __________ Usual Weight __________ Weight Goal _________

Highest Adult Weight & Year __________ Lowest Adult Weight & Year _______________

At what weight did you feel good about yourself and why: ____________________________

____

List changes you have made in the past for weight change and/or improved health: _________

____

Did you consider yourself successful in previous changes and what contributed to your success?

____

____

____

Rate the "Readiness" you now have for change:

____None ____ Low ____ Moderate ____ High ____ Very High

What is motivating you at this time to make behavior changes:

____

____

What in your life at this time would make behavior change more difficult (for example, travel, lack of support, etc.):

____

____

LIFESTYLE/SOCIAL HISTORY:

Do you smoke? ____________ If Yes, how much per day/week? ___________________________

Do you drink alcohol? __________ If Yes, what type(s), how much, how often? _________________

____

Do you exercise? __________ Has your Doctor approved exercise for you? ________

If Yes, list type of exercise: ______________ Amount in minutes: ___________________

Number of times per week _______________

EATING PATTERNS:

Typical Eating Times: Breakfast: _________ Lunch: __________ Dinner: __________

Any food allergies/intolerances? _______ If yes, please list __________________________________

Number of meals eaten in restaurants per week: ____

Types of restaurants: ____

FOOD FREQUENCY QUESTIONNAIRE

How often do you eat the following foods per week?

Food Item	# Per Week	Food Item	# Per Week	Food Item	# Per Week
Bread		Beef/Pork		Nuts	
Cereal		Chicken/Turkey		Fruit	
Rice/Pasta		Fish		Fruit Juice	
Bagels/Muffins		Shellfish		Sweets (cakes, cookies)	
Salty Snacks		Eggs		Sugar-free sweets	
Potatoes		Peanut Butter		Ice Cream	
Dried Beans/ Peas		Cheese		Coffee / Tea	
Corn, Peas, Lima Beans		Bacon/Sausage		Carbonated Beverages	
Vegetables (broccoli, carrots, etc.)		Luncheon Meats/ hot dogs		Alcohol	
Margarine/butter		Milk List type: ______		Fast food/ carryout	
Oil in cooking		Yogurt		Fried Foods	

SAMPLE

Food Log:

Please list everything you eat and drink from the time you wake up to the time you go to bed. Please also list an approximate amount of the foods you eat. An example is provided below for you.

TIME	FOOD	AMOUNT	COMMENTS
8:00am	Kellogg's Bran Flakes	¾ cup	
	1% Milk	1 cup	
	Banana (6")	1	
	Decaf Coffee	2 cups (10oz mug)	
	Lite Coffee Creamer	2 teaspoon (tsp)	
	Sugar	1 tablespoon	

FOOD LOG – Day 1:

Please list everything you eat and drink from the time you wake up to the time you go to bed. Please also list an approximate amount of the foods you eat.

TIME	FOOD	AMOUNT	COMMENTS

FOOD LOG – Day 2:

Please list everything you eat and drink from the time you wake up to the time you go to bed. Please also list an approximate amount of the foods you eat.

TIME	FOOD	AMOUNT	COMMENTS

FOOD LOG – Day 3:

Please list everything you eat and drink from the time you wake up to the time you go to bed. Please also list an approximate amount of the foods you eat.

TIME	FOOD	AMOUNT	COMMENTS