

This is what the client needs to download from Wellness & Weight Control Programs**Susan Burke March Registered Dietitian LLC**

Dear Client,

I am looking forward to providing you with high-quality, personalized coaching and counseling to help you achieve your health and nutrition-related goals. Attached you will find a nutrition/lifestyle questionnaire. So we can make the most of our appointment time fax the completed form prior to our initial meeting. Also, please bring the following to your appointment:

1. If we are meeting to improve your health please bring a copy of your most recent laboratory results. Labs can be faxed directly to me in advance if you prefer.

386-439-2980.

2. Signed Policies and Privacy Rights (HIPPA form) forms (you may fax in advance to **386-439-2980**

DIRECTIONS

Our initial meeting will be scheduled at your convenience, in your home or office, or in my home at 1090 Lambert Ave Flagler Beach, FL 32136. Head east on Route 100 (Moody Blvd) exit 284 off I-95, make a right (2.4 miles) at Connecticut Ave (the last light before the bridge over the Intracoastal Waterway—across from Wadsworth Park, just east of the new Publix plaza). Stay left, onto Palm Dr (continue parallel to Rt 100 under the bridge). Go 0.4 miles, and at Lambert Ave (the end--you can't go any further) turn left; continue 0.8 miles to 1090 Lambert Ave, on the **right**. Please park in the driveway.

If you have any questions or need to reach me, please call 386-439-2980 or email me at sburkerd@gmail.com

Sincerely,

Susan Burke March
MS, RD, LD/N, CDE

Susan Burke March Registered Dietitian LLC

All personal history is confidential

NUTRITION HEALTH HISTORY: Please download and complete this form and mail or fax prior to our initial face-to-face visit. If you are not able to complete prior to our initial visit, we will complete it together during our visit.

Fax: 386-439-2980

Mail to: 1090 Lambert Ave Flagler Beach, FL 32136

I Personal History

Name: _____ **DOB:** _____

Address: _____ **City** _____ **Zip** _____

Best Phone: _____ **2nd Phone** _____

E-mail: _____

Physician Name: _____ **Physician Phone:** _____

Occupation: _____ **Type of work/hours:** _____ N/A

Marital Status: Single Married Widowed Divorced

Living situation: Live alone Live with: _____

II Health Review

1. Do you have any **medical problems/concerns**? No Yes *please describe*

2. Are you under a **doctor's care** for any of the following conditions?

Diabetes Heart disease/Stroke/Circulatory High blood pressure Cancer

High blood fats Overweight Osteoporosis/Osteopenia (bone loss) Other-please describe: _____

3. **Any Family history of:** Diabetes Heart disease/Stroke/Circulatory High blood pressure Cancer: type? _____ who? _____ Other: _____

4. Please describe the **level of stress** you are experiencing on a scale of 1 to 10 (1 being lowest) if any: Current sources of stress _____

5. Have you had any **recent lab results** that were abnormal? No Yes- please describe which labs were not normal: _____

6. **Digestive problems?** None Constipation Diarrhea Gas Bloating
 Other: _____

7. Please LIST **MEDICATIONS YOU CURRENTLY TAKE:**

Type:	Dose:	Purpose:
_____	_____	_____
_____	_____	_____

8. Please LIST **DIETARY/HERBAL SUPPLEMENTS YOU TAKE including vitamin and mineral supplements:** (please bring bottles to your visit)

Type:	Dose:	Purpose:
_____	_____	_____
_____	_____	_____

9. Do you have any **food intolerances?** No Yes please list _____

10. Do you have any **allergies** (food, medication, environmental)? No Yes:
list: _____

Has your **doctor** made this diagnosis? No Yes Are you being **treated?** No Yes

11. Do you **smoke?** No Yes- amount? _____

III Activity & Exercise

1. Do you **Exercise?** Never Sometimes Daily

Walking Biking Swimming Aerobics Free weights Machines

2. Do you belong to a **gym?** No Yes if yes, how many visits/week? _____

3. Do you work out with a **personal trainer?** No Yes

4. **Other Regular Activities:** please describe _____

How Often? _____ How long? _____

5. Do you have problems **sleeping?** No Yes If yes, just a few words of explanation, please _____

IV Weight & Nutrition

Age: _____ Height: _____ Current Weight: _____ Goal Weight: _____

1. You think you are: overweight underweight Just right
2. Have you tried to lose weight in the past? No Yes, how many times? _____
3. If yes, what method or diet worked for you? _____
how many pounds? _____
4. If you regained, please check all some none (I've kept it all off)
5. How would you describe **your current** meal/food/diet plan?

6. How often do you feel **your eating** is "on track" Never 25% 50% 75%
 90-100%
7. Describe your **appetite** I'm always hungry Normal Depressed/poor
8. Do you **skip** meals? No Yes Which Meals? Bf Lunch Dinner
9. How often do you feel "stuffed" after eating? _____
10. Do you ever feel out of control when eating? No Yes
How often? Please describe

-
11. **What prevents you from reaching your dietary goals? Check all that apply:**
 Unsure of how to reach health goals Cravings Food binges Busy schedule
 Budget Lack of support (partner/family) Work environment Hate to exercise

Other weight history comments _____

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12. Who grocery shops in your household? _____ How often? _____
 13. Who cooks or prepares meals in your household? _____
 14. **IMPORTANT** please indicate dine-in/take-out/fast-food weekly

Meal	Times per week	Dine In or Take Out	List restaurants/ types of meals & snacks
Breakfast			
Lunch			
Dinner			
Snacks (include coffees)			

15. **If you do not drink alcohol, skip this question:**

Please indicate type and number of drinks you may consume daily

Alcoholic Beverage	Daily servings (5 oz wine or 12 oz beer or 1.5 oz spirits)
Mixed drinks	
Beer	<input type="checkbox"/> Regular _____ <input type="checkbox"/> "Lite" _____
Wine	
Other Please list	

16. **Beverages:** Please complete your usual beverage selections and amounts per day

Beverage Type	Serving size (ounces, cups)	How many per day?
Fruit Juice		
Coffee with <input type="checkbox"/> Cream or half & half <input type="checkbox"/> whole milk <input type="checkbox"/> nonfat milk <input type="checkbox"/> sugar		
Hot Tea with <input type="checkbox"/> Cream or half & half <input type="checkbox"/> whole milk <input type="checkbox"/> nonfat milk <input type="checkbox"/> sugar		
<input type="checkbox"/> Regular soda <input type="checkbox"/> Diet soda		
Coffee drinks (Starbucks or other sweetened)		
Iced Tea or Iced coffee <input type="checkbox"/> bottled <input type="checkbox"/> home-brewed)		
Water		
Other (please list)		

17. What are some of the **foods you eat or drink or stay away from** to keep you healthy? _____

18. What would you like to **accomplish from nutrition counseling?** (What specific nutritional issues or questions would you like to address?) _____

19. How many days per week are you willing to **track your foods and activities** to understand your current situation and identify strategies for change leading to improved habits?

1 time weekly 3 days weekly 5 days weekly every day

20. How confident are you that you will be able to make significant changes to improve your weight and your health?

very confident somewhat confident not confident ask me again later

**Important: prior to our first meeting,
RECORD YOUR USUAL FOOD INTAKE**

This sets the baseline so that we can work on priorities and strategies for positive change:

NOTE: I will provide you a Group Code so that you may register for Nutriinfo.com's Diet Manager and use the Online Nutrition Tracker for your convenience

You may also create a food log here: Please record the time, typical types of foods eaten & amounts below. Please also describe eating habits on weekends versus workweek.

Breakfast I usually eat at O'clock or I skip breakfast days/week

One breakfast I often eat is:

Another breakfast I sometimes eat is: _____

A.M. snack I usually eat at O'clock or I **don't** eat this snack days/week

The snacks I often eat are: _____

Lunch I usually eat at O'clock or I **skip** lunch days/week

One of the lunches I often eat is:

Another lunch I sometimes eat is: _____

Afternoon snack I usually eat at O'clock I **don't** eat this snack days/week

The snacks I often eat are: _____

Evening Meal I usually eat at O'clock or I **skip** supper days/week

One of the meals I often eat is:

Another evening meal I sometimes eat is: _____

Evening snack I usually eat at O'clock I **don't** eat this snack days/week

The snacks I often eat are:
