MAJOR METABOLIC METHOD

CANCELLATIONS

We ask that you please provide at least 24 hours notice for all cancellations and rescheduling of appointments. Cancellation of appointments or failure to attend may attract a cancellation fee as follows:

- Payment of 100% of the fee if less than 24 hours notice provided

It is not our aim to make profits from cancellation fees, rather to make sure those appointment times are kept available for others who need them, and in order that you respect your dietitian's time.

We do appreciate that, in some circumstances, short notice may occasionally be unavoidable, and discretion will be exercised in such cases.

_____

I have read, understood and accept the dietitian cancellation policy.

Signed _____ Dated _____ Name _____ (please print)

One's health and well-being are influenced by many different things, including lifestyle, family history, emotional health, and nutrition/eating habits. Please complete the following questionnaire to the best of your ability to give us an overall view of your general lifestyle and health habits.

New Patient Nutrition Assessment Form

First Name:_____Middle Name:_____Last Name:_____
Address:_____ City:_____State:____Zip:_____

Please indicate your preferred method of contact: home work cell email

Home Phone: (_____)_____-_____ Birth Date:_____/_____/_____Age:_____

Work Phone: (_____)_____-_____ Email:_____

Cell Phone: (_____)_____-_____ Height: __ Weight: __Sex: _____

Blood Type (Please Circle): A / B / AB / O

Occupation:_____ Marital Status:_____

Do you have children? Yes No Age of Children: _____

Are you pregnant? Yes No Due Date_____ Preferred Consultation Method:
Remote In Person

With whom do you live? (Include children, parents, relatives, and/or friends. Please include ages.)
Example: Sarah, age 7, sister _____

_____

Primary Care Provider:_____Date of last physical exam:_____

Other doctors or practitioners you see:_____

Date of last bloodwork:_____ Ordered by:_____

GOALS AND READINESS ASSESSMENT:

I would like to visit with Dr. Major, today because…

_____

_____

_____

My food and nutrition-related goals are…

_____

_____

_____

My overall, health goals are… _____

_____

_____

If I could change three things about my health and nutritional habits, they would be…

1. _____

   _____

2. _____

   _____

3. _____

   _____

The biggest challenge(s) to reaching my nutrition goals is/are:

_____

_____

_____

_____

In the past, I have tried the following techniques, diets, behaviors, etc. to reach my nutrition goals…

_____

_____

_____

_____

On a scale of 1 (not willing) to 5 (very willing), please indicate your readiness/willingness to do the following:

To improve your health, how ready/willing are you to…	1	2	3	4	5
Significantly modify your diet					
Take nutritional supplements each day					
Keep a record of everything you eat each day					
Modify your lifestyle (work demands, sleep habits, physical activity)					
Practice relaxation techniques					
Engage in regular exercise/physical activity					
Have periodic lab tests to assess your progress					

PAST MEDICAL AND SURGICAL HISTORY:

Please indicate whether you or your relatives* have been diagnosed with any of the following diseases or symptoms (specify which relative and the date of diagnosis). *Relatives include parents, grandparents, siblings.

Illness/Disease/Symptom	Self: Age Diagnosed	Relative: Age Diagnosed	Describe/Specify
Allergies (specify type)			
Anemia			
Anxiety/Panic Attacks			
Arthritis (osteoarthritis or rheumatoid)			
Asthma			
Autoimmune condition (specify type)			
Bronchitis			
Cancer			
Chronic Fatigue Syndrome			
Crohn's Disease or Ulcerative Colitis			
Depression			
Diabetes (specify type)			
Dry, itchy skin, rashes, dermatitis			
Eczema			
Emphysema			
Epilepsy, convulsions, seizures			
Eye Disease (specify type)			
Fibromyalgia			
Food Allergies or sensitivities			
Fungal infection (athlete's foot, ringworm, other)			

Gallbladder disease/Gallstones (specify)			
Gout			
Heart attack/Angina			
Heartburn			
Heart disease (specify)			
Hepatitis			
High blood fats (cholesterol, triglycerides)			
High Blood Pressure (hypertension)			
Hypoglycemia (low blood sugar)			
Intestinal disease (specify)			
Irritable bowel syndrome			
Kidney disease/failure or kidney stones			
Lung disease (specify)			
Liver disease			
Mononucleosis			
Osteoporosis			
PMS			
Polycystic ovary syndrome			
Pneumonia			
Prostate problems			
Psychiatric conditions			
Sinusitis			
Sleep apnea			
Stroke			
Thyroid disease (hypo- or hyper-)			
Urinary tract infection			
Other (describe)			
Injuries	**Age**	**Describe/Specify**	
Back injury			
Broken (specify)			
Head injury			
Neck injury			
Other (describe)			
Diagnostic Studies	**Age**	**Describe/Specify**	
Barium enema			
Bone Scan			
CAT Scan (specify)			
Chest X-ray			
Colonoscopy/Sigmoidoscopy			
EKG			
Liver scan			
NMR/MRI			
Upper GI series			
Other (describe)			

Operations	Age	Describe/Specify
Dental surgery		
Gallbladder		
Hernia		
Hysterectomy		
Tonsillectomy		
Other (describe)		

MEDICATION, SUPPLEMENT, AND ANTIBIOTIC INTAKE:

Please provide the names of medications, supplements, and/or antibiotics that you are currently taking:

Medication/Supplement/Antibiotic	Dose	Units	Frequency	Start Date	Stop Date
Example: One-a-Day Multivitamin	1200	mg	Daily	02/17/2019	current

Are you allergic to any medications? Yes No Please list: _____

Please circle how often you have taken antibiotics during each life stage:

Infancy: <5 times >5 times

Teen: <5 times >5 times

Adulthood: <5 times >5 times

LIFESTYLE:

Physical Activity: Using the table, please describe your physical activity.

Activity	Type/Intensity	# Days per week	Duration (minutes)
Stretching/Yoga			
Cardio/Aerobics (walking, jogging, biking, etc.)			
Strength training (weight lifting, pilates, etc.)			
Sports or Leisure			
Other (specify/describe)			

Does anything limit you from being physically active?

_____

Indicate daily stressors and rate the level of stress from 1 (extremely low) to 10 (extremely high): Work_____
Family_____Social_____Financial_____Health_____ Other_____

What helps you to unwind?_____

On average, how many hours of sleep do you get? Weekdays_____ Weekends_____

Do you smoke? Never In the past Currently How long?_____

Alcohol use? Never In the past Currently Type/amount/frequency_____

Drug use? Never In the past Currently Prefer not to discuss Type/frequency_____

WEIGHT HISTORY:

Would you like to be weighed today? Yes No

Height _____ Current Weight _____ Desired Body Weight _____
Highest Adult Weight _____ When? _____ Weight 1 year ago _____

Have you had any recent changes in your weight that you are concerned about? Yes No If yes, please explain:_____

DIGESTIVE HISTORY:

Do you associate any digestive symptoms with eating certain foods? Yes No

Please explain:_____

_____

How often do you have a bowel movement? _____

If you take laxatives, what type/brand and how often?

_____

Would you describe your stools are hard, soft, or loose? (circle one)

Please circle how often you experience the following symptoms:

Heartburn- Sometimes Rarely Often

Gas- Sometimes Rarely Often

Bloating- Sometimes Rarely Often

Diarrhea- Sometimes Rarely Often

Nasea/Vomiting- Sometimes Rarely Often

Stomach Pain- Sometimes Rarely Often

Constipation- Sometimes Rarely Often

DIET HISTORY:

Do you follow any special diet or have diet restrictions or limitations for any reason (health, cultural, religious or other)? Yes, please describe No

Please list any food allergies, sensitivities or intolerances _____

_____

Who prepares the majority of your meals? _____Who shops for food?_____

Where do you shop for food? _____

What percent of the foods you eat are… whole _____% organic_____% convenience _____%

If you do, how much time do you spend cooking/preparing meals each day? _____

Please check the materials you use for cooking and food storage:

Plastic

Glass

Aluminum

Styrofoam

Stainless Steel

Cast-iron

Teflon

Ceramic

Do you find cooking difficult? Yes No Please describe_____

INTAKE INFORMATION:

If you follow a special diet/nutritional program, check the following that apply:

Low Fat

Low Carb High Protein

Low Sodium

No Gluten Vegetarian

Vegan

Diabetic

No Dairy

No Wheat

Weight Loss

Other_____

Which meals do you eat regularly, circle all that apply:

Breakfast Lunch Dinner Snacks (time)_____

The nutrition/eating habits that are most challenging for me: _____

_____

The nutrition/eating habits that I am most pleased with: _____

_____

Beverage Intake: Please indicate the beverages you drink, and how often you drink them. Fill in the "Daily Amount" and "Weekly Amount".

Beverage Type	Daily Amount	Weekly Amount
Water: tap filtered bottled		
Coffee: reg decaf latte		
Tea: types? _____		
Juice: natural fruit drinks		
Soda: regular diet		
Milk: 2% 1% skim alternative		
Alcohol: wine beer liquor		
Other: _____		

Food Intake: Please indicate the frequency that you eat the following:

How often do you eat:	Never	2-3 times/mo	1 time/week	2-3 times/week	1 time/day	2-3 time/day
Fast food						
Restaurant food						
Vending machine food						
Cafeteria/Buffett food						
Frozen meals						
Home-cooked meals						
Leftovers						
Beef (hamburger, steak, etc)						
Pork (chop, loin, ham, bacon, etc)						
Liver						
Lamb						
Poultry (chicken, turkey, etc)						
Deli meat, type:						
Fish, type:						
Soy foods, type:						
Beans, type:						
Crackers, type:						
Cookies, cakes, muffins						
Whole grains, type:						
Fresh/Raw vegetables						
Cooked vegetables						
Fruit (fresh or frozen)						
Canned fruits or vegetables						
Margarine						
Dairy (milk, cheese, yogurt, butter)						
French fries						
Fried meat (chicken, fish)						
Foods with added sugar/sweetener, type:						
Artificial sweeteners						
Meal replacements, type:						

Food cravings: _____

_____

Food dislikes: _____

_____

Eating Style: Based on how you eat on a regular basis, please check all that apply:

Fast eater

Erratic eater

Emotional eater

Late night eater

Time constraints

Dislike healthy food

Travel frequently

Rely on convenience items

Do not plan meals

Love to eat

Eat too much

Eat because I have to

Confused about food Poor snack choices Eating issues

Frequently eat fast food

Family members have different tastes

Negative relationship with food

The food/nutrition questions I would like to ask are: _____