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| Nutrition Screening form:  (To be completed by patient prior to 1st apt w/RD  or with parent/guardian and pt if pt is a minor prior to 1st apt w/RD) |

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| Name: | DOB:  Do you smoke?: |
| Height: | Weight: |
| Date of your last physical exam AND bloodwork? | Do you have any lab values that are abnormal? (if yes, please describe) |
| Does your Dr. have any concerns regarding your health? (if yes, please describe) | Do you have a family history of hypertension, diabetes, cancer, high cholesterol, high triglycerides or other health conditions? (if yes, please describe) |
| #1 Goal in meeting w/a Registered Dietitian: | |
| Chewing/swallowing problems? If yes, please explain. | |
| Who does the cooking and grocery shopping at home? | |
| Food Allergies or Intolerances: | |
| List foods you do not like: | |
| How many meals/day do you normally eat? | How many snacks/day: |
| Do you normally eat and snack around the same times every day? | |
| List all foods normally eaten at breakfast: | |
| List all foods normally eaten at lunch: | |
| List all foods normally eaten at dinner: | |
| List all foods normally eaten for snacks: | |
| List all drinks normally consumed on a weekly basis: | |
| How many days/week do you normally eat out (restaurant or fast food)? | List most frequent restaurants/fast food places you usually eat at: |
| Do you experience nausea, vomiting, constipation and/or diarrhea regularly?   * If yes, please describe: | |
| Do you exercise regularly?   * If yes, please describe how many days/week, how many minutes/day and the activity: | |
| What is your favorite type of exercise and why? | |
| Please list any medical diagnoses w/date of diagnosis: | |
| Please list any past surgeries w/dates: | |
| Please list any OTC and/or prescription medications you are currently taking: | |
| Are you currently following a special diet or meal plan?   * If yes, please describe: | |
| Have you ever followed a special diet or meal plan?   * If yes, please describe: | |
| Have you ever received nutrition counseling before?   * If yes, please describe: | |
| What challenges are in your life are keeping you from meeting your nutrition and exercise goals? | |

**At least 3 days before our 1st appointment**:

1. Submit this form to your dietitian and
2. Fax over your most current blood work from your medical doctor

(Fax: 310.833.6569)

**Please bring the following with you to our first appointment:**

1. Valid photo ID
2. Insurance cards (if we are going through insurance)
3. Current medications
4. 5 day food journal w/all food, drinks and portion sizes consumed
5. New patient paperwork

**Thank you for your Time ☺**