WELCOME LETTER

Congratulations. You've made a decision to improve the quality of your life through nutrition therapy. This involves not only addressing what you eat, but also how you think and feel about food and your body. This is not a one size fits all approach. We will strive to understand your needs, preferences, and goals in order to offer realistic and personalized solutions for your nutrition and health concerns. We hope to create a relationship built on trust so that we can honestly and openly communicate with one another.

Because our habits are deeply engrained, making changes that will last a life time occurs in stages and often takes time. Be patient. People often wonder how many times we'll need to meet. That entirely depends on the purpose of our meeting, your goals, your readiness to change, what support systems you have in place, and many other factors. While we might not be able to answer that question definitely, here's what you can expect.

Initial session: 60 minutes
Lifestyle and nutrition assessment, baseline goal setting and development of nutrition and/or exercise care plan based on your needs. ***Please bring the following items to your first appointment****.

1) **The Getting Started Packet:**
   - ☐ New Client Registration
   - ☐ Nutrition Consultation Questionnaire

2) **OPTIONAL: 3 Food Logs**

***Do your best to have all of this information filled out for our first session. If you become overwhelmed, have trouble or don't feel comfortable answering any of the questions, leave it blank! If there is additional info you'd like to include, please feel free to do so.**

Subsequent sessions: 50 minutes
Re-evaluation of your nutrition and/or exercise care plan, review of goals and objectives, evaluation of follow up laboratory work (as needed), discussion about other resources that may help you meet your goals (i.e. nutritional supplements, working with a therapist, books to read, etc).

I look forward to working with you.

Sincerely,

Alisa Garner, RDN,LD,CDE

New Client Registration

Name			DOB		
I-Number					
Marital Status		Hometown:	Client's Semester:	Sex	M F

Contact Information- please circle your preferred contact method

Telephone-Day/Evening		Cell Phone	
Email Address			

Primary Care Physician

Name		Phone #	
Address			
Relationship with Physician (i.e. what do you seen him/her for, when was your last apt, etc.)			

Psychotherapist/Counselor

Name			
Relationship with Therapist (i.e. how long have you been seeing them, how often do you see them, etc.)			

Nutrition Consultation Questionnaire

Name: Age: Date:

Occupation (what is your major, are you working, and are how do you feel about it?):

Who do you live with?

Emergency Contact: Phone:

Family History

Tell me about your family and family dynamics:

What was food like in your house growing up? What's it like now?

Does anyone in your family have a history of chronic illness including (an eating disorder, diabetes, heart disease, high cholesterol, high blood pressure)?

Purpose of Consult

Tell me about the primary purpose of our meeting.

Weight Information- if this section feels uncomfortable, leave it blank and we can discuss it together

Height: Age: Current wt: Ave wt for the past 2 to 3 years?

Weight where you feel most comfortable? When were you last at that weight?

Highest adult weight? Age: Lowest adult weight? Age:

Pre-pregnancy weight (if applicable)? How much weight did you gain with pregnancy (if applicable)?

Have you lost or gained weight recently? How much? Time frame?

Do you weigh yourself currently? If yes, how frequently?

Please check how you currently feel about your body.

strongly dislike dislike slightly satisfied satisfied very satisfied

Dietary History

Tell me about your dieting history (types of diets, amount of weight lost, short/long-term results, etc.)

Eating Patterns

How many meals a day do you eat? Do you skip meals?

If yes, which ones do you skip and why?

What are your snacking habits (i.e. frequency, time of day, foods you choose)?

How many meals per week do you eat at a restaurant?

Which restaurants do you normally choose?

How does your meal and snack pattern vary on the weekend vs. during the week?

When you feel overwhelmed or life gets busy, do you neglect your eating habits? yes no

If yes, please describe.

Do you feel that your life/schedule often conflicts with a healthy eating program? yes no
If yes, please describe.

Do you engage in other activities while eating (i.e. reading, driving, watching TV)? yes no

Do you cook? yes no

Do you like to cook? yes no
Do you eat at the table? yes no

Do you feel you eat fast? yes no

Who does the grocery shopping? Who prepares the food at home?

Do you read food/nutrition labels? yes no

What do you look for on labels?

Please list the usual time that you the following meals and your typical daily intake for each meal.
Breakfast:

Lunch:

Dinner:

Snacks:

What foods do you love?

What foods do you dislike?

Are there any foods that feel like binge foods for you?

Are there any foods that feel "safe" to you?

Does your diet have a lot of variety or does it tend to be the same from day to day?

Do you have any food allergies? If yes, please list:

Exercise and Activity

Have you ever had a consistent exercise routine? yes no Are you following one currently? yes no

If yes, please describe:

Tell me how you feel about exercise (what you like, don't like, etc.)

Personal Health & Medical History

Please list/describe any medical diagnoses or procedures I should be aware of.

If applicable, are you currently getting your period?

Please list your current medications & supplement dosages:

Please list/describe any mental health concerns I should be aware of (ie depression, anxiety, OCD, PTSD)?

Please share any illicit drug, alcohol, cigarette use.

Rate your health: excellent good fair poor

Rate your current perceived level of stress on a scale of 1-10:

Sleeping habits (Total and Quality):

On a scale of 1-10, 10 being the highest, how much support do you need when making lifestyle changes?
Do you have a strong support system? Please describe.

Have you ever been advised by your physician to follow a special diet? (i.e. low salt/cholesterol, etc)
yes no What changes did you make at that time?

Have you ever worked with a dietitian/nutritionist? yes no If yes, what was your experience?

Nutrition Consultation

What do you hope to accomplish through our visit?

What are your short-term goals?

What are your long-term goals?

Please feel free to share any additional information here.

Daily Food Log Day and Date: _____

Time	H	Food & Beverages/Amount	F	Details: Trigger "The Why?", Feelings/Moods, Thoughts, With Who, Where
		B:		
		S:		
		L:		
		S:		
		D:		
		S:		

Hunger and Fullness Scale:

1 = Starving	2 = Very Hungry	3 = Ready for a Meal	4 = Edge of Hunger, Snack Time	5 = Neutral	6 = Mildly satisfied-like after a snack	7 = Satisfied-like after a meal	8 = Pretty Full- 2 bites too many	9 = Very full, uncomfortable	10 = Stuffed, need to lie down