Nutrition Assessment

pure nutrition
helping you make healthy choices

Welcome to Pure Nutrition! We take a holistic approach to your overall health and well-being. As your Registered Dietitian, it is important to get to get to know you better including your current health and lifestyle. Please complete these forms to help us better develop a personalized plan for you!

Name: _____ Appointment date: _____

Contact Information:
Address:_____
City: _____ Province: _____ Postal Code: _____
Phone # : _____ E-mail: _____

Gender : _____ Birth date: _____ Age:_____

Physician's Name_____ Specialist:_____

How did you hear about Pure Nutrition? Google:_____ Dietitians of Canada website:_____
Friend:_____ Doctor:_____ Other:_____

Reason for seeking Nutrition Counselling:
_____
_____

What are your expectations from this visit?_____
_____

What are your expectations from me?_____
_____

Have you ever seen a Dietitian in the past? If so, when? What did you find useful/ not useful?
_____
_____

How would you describe your general health?_____
_____

On a scale of 1-10, how committed are you to making lifestyle changes?_____

What if any, obstacles do you foresee are preventing you from making changes?_____
_____

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Anthropometrics and weight history:

Current Weight: _____ Height: _____

What are your weight goals?_____

Details on weight history_____
_____

When have you lost gained/ weight? Any changes in your life at that time?_____
_____
_____

Lifestyle:

How many times per week do you exercise? _ Never _ < 1/wk _ 1-3/wk _ 3-5/wk _ >5/wk

What types of exercise do you do? _____

How long do you spend exercising each time?_____

Energy level (please circle): Low 1 2 3 4 5 6 7 8 9 10 High

Do you experience fatigue? Y / N What time of day:_____

Who does the grocery shopping/ cooking in the house?_____
_____
Who do you live with?_____

What is your work schedule like? Type of work? _____
_____
How many hours a week do you work on average:_____

Do you sleep well? Y / N
Do you wake feeling well rested? Y / N
How many hours/ night do you typically sleep? _____
When do you typically go to bed/ wake:_____

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Stress:

What are the major stresses in your life? (i.e. financial, job related, health, family)
1._____
2._____
3._____
4._____
Indicate your current stress level on a scale of 1-10: Low 1 2 3 4 5 6 7 8 9 10 High

How do you deal with stress? _____
Does this approach help sufficiently? _____
What do you do for recreation? (i.e. What are your hobbies and interests?)
_____

Medical History (check all that apply):

Diabetes ____	Osteoporosis ____	High blood pressure ____
High Cholesterol ____	Heart Disease ____	Cancer ____
Kidney Disease ____	Liver Disease ____	Thyroid Disease ____
Anemia ____	Depression ____	Smoker ____
Nausea ____	Vomiting ____	Acid Reflux ____
Diarrhea ____	Constipation ____	Ulcers ____
IBS ____	Diverticulitis ____	Crohns/IBD ____
PCOS ____	Chronic Fatigue ____	Fibromyalgia ____

Other (please list): _____
_____

<u>Females Only</u>
Are you pregnant? Yes No Are you breastfeeding: Yes No

Family medical history (if relevant): _____
_____
Relevant Bloodwork:_____
_____

List all vitamin, herbal supplements and medications you are currently taking:
Med/ Supplement Amount: Reason for use:
_____
_____
_____
_____

Do you avoid any foods? (Allergies, intolerances, preferences)
_____
_____

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Waiver and Acknowledgement

I, _____ hereby grant permission for my Registered Dietitian (please circle): *Heather Janicki, RD / Julie Kostyk, RD / Jodi Holland, RD* to correspond with my physician(s) to obtain information relevant to my nutrition treatment and counselling. I acknowledge that any information so obtained will be held in strict confidence.

I further acknowledge the information provided to me by my Registered Dietitian is designed to meet my personal dietary needs. It is not suitable for any other individuals and will not be transferred, copied or sold to another person.

In order to benefit from the treatment prescribed by my Registered Dietitian I realize that it is important for me to inform either my physician or my Registered Dietitian of any changes I make in the application of my diet. It is my responsibility to report any side effects or problems immediately and to make the necessary adjustments to my treatment plan with my physician and/or my Registered Dietitian. I will not hold my physician or my Registered Dietitian responsible for any complications that result from my failure to comply with either of the above.

I have agreed to have my Registered Dietitian keep records of our visits and to file these in a secure and appropriate place. I have agreed to have my Registered Dietitian communicate with me via email following my appointment, including sending me a copy of my invoice/receipt as well as any client reports. If deemed beneficial to my care, I have agreed to allow my Registered Dietitian to contact other healthcare professionals. I acknowledge that only relevant personal information will be shared and that this may be accomplished by letter, phone, fax, or email.

Cancellation policy:

Twenty-four (24) hours notice is needed to cancel/reschedule your appointment, otherwise a $50 charge will be applied.

Thank you for your cooperation and understanding.

Date:_____

Client's Signature:_____