DECO Nutrition Counseling Paperwork

HEALTHY LIVING
DIABETES & ENDOCRINOLOGY CENTER OF OHIO

Patient Name: _____

Primary Insurance: _____

Phone #: _____ **Email Address:** _____

Occupation: _____ **Marital Status:** _____

PCP: _____

Have you seen a dietitian before? ☐ Yes ☐ No

Reason for visit or consult:

_____

_____

Height: _____ **Weight:** _____ **Usual Weight:** _____ **Desired Weight:** _____

Medical History (any current or past health conditions that you suffer/ed from):

_____

_____

_____

Family Medical History (any medical problems your immediate family suffers/ed from):

_____

_____

Hospitalizations and/or surgeries (Year/reason):

_____

_____

Current Medications/vitamins/supplements:

_____

_____

Allergies to Medications: _____

Do you smoke or have ever smoked? _____

Do you drink alcohol? _____ **If so, how much?** _____

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NUTRITION AND WEIGHT HISTORY

Have you lost or gained any weight in the past 12 months? How much? _____

If weight loss is your primary concern or priority, what are your main reasons?

☐ Concerned about Diabetes ☐ Overall Health ☐ Promote Social Activity ☐ Appearance ☐ Advised by Physician

☐ To please others ☐ Special Occasion ☐ Other, Explain: _____

Have you tried any weight loss methods in the last 5 years?

☐ Weight Watchers ☐ Diet Books ☐ Weight Loss Medications ☐ Do It Yourself ☐ Other Diet Centers ☐ Physicians

☐ Other _____

Why have you dropped out of other diets/programs before?

_____

Current challenges with your diet:

_____

How often do you exercise?

☐ Rarely ☐ Occasionally ☐ 1-2 times per week

☐ 3-4 times per week ☐ 5 or more times per week

Type of exercise you do _____

Has your doctor or any medical professional ever told you not to exercise? _____

Have you ever been taught carbohydrate counting? □ Yes □ No

Do you follow a special diet?

☐ Diabetic ☐ Vegan ☐ Gluten Free ☐ Low Salt ☐ Vegetarian ☐ Paleo ☐ None

☐ Other_____

Do you have any food allergies or sensitivities? ☐ No ☐ Yes (describe): _____

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Are you currently or regularly experiencing symptoms of:

☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Constipation ☐ Gas ☐ Reflux

Please list foods that you like most:

_____

Please list any foods that you do not like:

_____

How many meals do you eat out per week? _____ ☐ Fast Food ☐ Sit Down ☐ Take Out

Are these meals with family or friends? ☐ Yes ☐ No

Are you presently undergoing any major lifestyle changes? (Marriage, divorce, job change, grievance, financial stress, death of someone important to you?)

_____

_____

Do you suffer of have ever suffered from depression, anxiety, insomnia or disordered sleep patterns?

_____

Of the following, check all the items that best describe your eating habits:

☐ Thinking about food too much of the time
☐ Not paying attention to what I'm eating
☐ Eating high-fat foods
☐ Eating too many sweet foods
☐ Eating foods too quickly
☐ Uncontrollable binges
☐ Eating in reaction to emotions
☐ Eating to take my mind off other problems
☐ Overeating at social events
☐ Lack of satisfaction in life
☐ Eating in reaction to boredom
☐ Overeating when alone
☐ Using food as a reward
☐ Other _____

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Please describe a typical day's food intake.

Meal	***On a "Good Day"***	***On a "Bad Day"***
Breakfast		
Lunch		
Dinner		
Snacks		
Fluid intake (how many oz/day)		