

CURRENT NUTRITION INFORMATION

HILARY B. SHAW, M.S., L.D.N., R.D.

| FILL IN THIS COLUMN | DIETITIAN'S NOTES | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|---|--|--|---|---|--|---------------------------------|---------------------------------|---|----------------------------------|---------------------------------------|--|---------------------------------------|---|--|--|--|--|---|---|--|---------------------------------|---------------------------------|---|----------------------------------|---------------------------------------|--|---------------------------------------|---|--|--|
| <p>Name _____</p> <p>Date of Birth _____ Age _____ M F</p> <p>Reason for visit: _____</p> <hr/> <p>Names/Ages of People in your Household _____</p> <hr/> <p>Will family participate in any sessions? _____</p> <p>Describe the support of your family regarding the changes you plan to make: _____</p> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <p>Height _____ Weight _____ Desired Weight _____</p> <p>Date of: last physical _____ Lab tests _____</p> <p>Check any conditions family (extended blood relatives) have or have had:</p> <table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> heart disease</td> <td><input type="checkbox"/> high blood pressure</td> <td><input type="checkbox"/> diabetes/hypoglycemia</td> </tr> <tr> <td><input type="checkbox"/> high cholesterol</td> <td><input type="checkbox"/> osteoporosis/arthritis</td> <td><input type="checkbox"/> thyroid condition</td> </tr> <tr> <td><input type="checkbox"/> anemia</td> <td><input type="checkbox"/> cancer</td> <td><input type="checkbox"/> menstrual irregularities</td> </tr> <tr> <td><input type="checkbox"/> obesity</td> <td><input type="checkbox"/> malnutrition</td> <td><input type="checkbox"/> IBS/Crohn's/GI problems</td> </tr> <tr> <td><input type="checkbox"/> fibromyalgia</td> <td><input type="checkbox"/> chronic fatigue syndrome</td> <td><input type="checkbox"/> polycystic ovary syndrome</td> </tr> </table> <p>Check any conditions you have or have had:</p> <table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> heart disease</td> <td><input type="checkbox"/> high blood pressure</td> <td><input type="checkbox"/> diabetes/hypoglycemia</td> </tr> <tr> <td><input type="checkbox"/> high cholesterol</td> <td><input type="checkbox"/> osteoporosis/arthritis</td> <td><input type="checkbox"/> thyroid condition</td> </tr> <tr> <td><input type="checkbox"/> anemia</td> <td><input type="checkbox"/> cancer</td> <td><input type="checkbox"/> menstrual irregularities</td> </tr> <tr> <td><input type="checkbox"/> obesity</td> <td><input type="checkbox"/> malnutrition</td> <td><input type="checkbox"/> IBS/Crohn's/GI problems</td> </tr> <tr> <td><input type="checkbox"/> fibromyalgia</td> <td><input type="checkbox"/> chronic fatigue syndrome</td> <td><input type="checkbox"/> polycystic ovary syndrome</td> </tr> </table> <p>List any other relevant medical conditions or any condition for which you've been treated in the last year: _____</p> <hr/> <p>Have you ever been advised follow any type of diet? If yes, by whom _____, what kind _____, and what changes did you make? _____</p> <hr/> | <input type="checkbox"/> heart disease | <input type="checkbox"/> high blood pressure | <input type="checkbox"/> diabetes/hypoglycemia | <input type="checkbox"/> high cholesterol | <input type="checkbox"/> osteoporosis/arthritis | <input type="checkbox"/> thyroid condition | <input type="checkbox"/> anemia | <input type="checkbox"/> cancer | <input type="checkbox"/> menstrual irregularities | <input type="checkbox"/> obesity | <input type="checkbox"/> malnutrition | <input type="checkbox"/> IBS/Crohn's/GI problems | <input type="checkbox"/> fibromyalgia | <input type="checkbox"/> chronic fatigue syndrome | <input type="checkbox"/> polycystic ovary syndrome | <input type="checkbox"/> heart disease | <input type="checkbox"/> high blood pressure | <input type="checkbox"/> diabetes/hypoglycemia | <input type="checkbox"/> high cholesterol | <input type="checkbox"/> osteoporosis/arthritis | <input type="checkbox"/> thyroid condition | <input type="checkbox"/> anemia | <input type="checkbox"/> cancer | <input type="checkbox"/> menstrual irregularities | <input type="checkbox"/> obesity | <input type="checkbox"/> malnutrition | <input type="checkbox"/> IBS/Crohn's/GI problems | <input type="checkbox"/> fibromyalgia | <input type="checkbox"/> chronic fatigue syndrome | <input type="checkbox"/> polycystic ovary syndrome | |
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| <p>Medications, including any over-the-counter, that you take and why:</p> <hr/> <hr/> <p>Vitamin, mineral, food supplements, and herbs that you take, and why:</p> <hr/> <hr/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <p>Do you:</p> <p>use any tobacco products? If yes, list type and frequency: _____</p> <p>drink alcoholic beverages? If yes, list type, amount and frequency: _____</p> <p>use any non-Rx drugs? If yes, list type, amount and frequency: _____</p> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

CURRENT NUTRITION INFORMATION

HILARY B. SHAW, M.S., L.D.N., R.D.

Food Intake and Habits

How many days per week do you skip:

breakfast _____ lunch _____ dinner _____

Do you snack? Y N

When? _____

Snack foods? _____

Circle the food group(s) you eat the most of, X through those you lack:

dairy protein fruit vegetables grains fats sweets

Favorite foods? _____

Least favorite foods? _____

How often do you eat out, and what do you usually order:

_____ breakfast _____

_____ lunch _____

_____ dinner _____

_____ snacks _____

Beverages: Amount (D)daily or (W)weekly:

_____ water _____

Who usually:

prepares your food? _____

does your grocery shopping? _____

If you read labels, what do you look for? _____

List others in your household with special diet needs: _____

List the primary factors that influence your food choices (i.e. too busy to cook, allergies): _____

Do you regularly eat: (check those that apply)

___ while standing ___ in the car ___ too fast

___ with others ___ at the table ___ watching TV

___ while doing other things ___ everything on your plate

How often do you weigh yourself? _____

How do the numbers on the scale influence your mood and eating habits?

If you want to lose weight, what is your primary motivation? _____

List programs, diets, supplements, etc. that you have used to control your weight: _____

How have they worked? _____

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| | |
|---|--|
| <p>Occupation: _____</p> <p>Describe your physical activity level on the job: _____</p> <p>_____</p> | |
| <p>Do you exercise? If yes, list type, frequency and duration, if no, why not: _____</p> <p>_____</p> <p>List other physical activities, such as hobbies and sports: _____</p> <p>_____</p> | |
| <p>Describe your usual stress level and primary stressors: _____</p> <p>_____</p> <p>How do you manage your stress? _____</p> <p>_____</p> | |
| <p>Describe how you've been feeling and if you have any unexplained symptoms: _____</p> <p>_____</p> | |
| <p>Food allergies or intolerances: Your reactions to the foods: _____</p> <p>_____</p> <p>_____</p> | |
| <p>What do you think is your most serious nutrition habit/problem? _____</p> <p>_____</p> <p>What is motivating you to change your nutrition and food habits? _____</p> <p>_____</p> <p>_____</p> <p>Any other information you think may be important for me to know: _____</p> <p>_____</p> <p>_____</p> | |
| <p>Check the topics of special interest to you:</p> <p><input type="checkbox"/> food skills and nutrition knowledge: non-diet living, label reading/shopping, cooking, kitchen/food prep skills, meal planning, food as medicine, eating out/holidays</p> <p><input type="checkbox"/> physical fitness: energy/activity, strength training, toning, aerobics, body composition analysis</p> <p><input type="checkbox"/> weight: loss/maintenance/weight gain, fat loss, gain lean body mass</p> <p><input type="checkbox"/> eating problems: diet obsession, body image issues, eating disorder</p> <p><input type="checkbox"/> life stage: infant/child, pregnancy/lactation, perimenopause, menopause, later years, athletics</p> <p><input type="checkbox"/> nutrition management of medical risk/problem: hypoglycemia, insulin resistant, diabetes, high blood pressure, cardiovascular disease, cancer, allergies, immune dysfunction (CFS, fibromyalgia, arthritis), PCOS, gastrointestinal problems (IBS, Crohn's)</p> <p><input type="checkbox"/> supplements: vitamins/minerals, antioxidants/phytonutrients, herbs</p> <p><input type="checkbox"/> optimum health: well-being, disease prevention</p> | |

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CLIENT INFORMATION

Name _____ Date _____

Parent's Names, if minor _____

Address _____

Zip _____

Phone (hm) _____ (wk) _____

Fax _____ Date of Birth _____

Name/address of person responsible for bill if other than client _____

Referred by _____

Will you be submitting expenses for nutrition services to your insurance? _____

AUTHORIZATION FOR RELEASE OF INFORMATION

Please provide the following if you have been referred by your physician and/or counselor. This will allow us to exchange records and work together for you.

I authorize: Hilary B. Shaw, M.S., L.D.N., R.D
765 Longwood Drive
Baton Rouge, LA 70806
(225)387-3691 phone

to exchange records and discuss my case with:

regarding medical/counseling information related to the nutritional health of the above registered client.

Signature of Client or Responsible Party

Date