



Healthy Habitudes, LLC
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Preparing for Your Nutrition Consultation

- ✓ Please complete the following *Nutrition History Questionnaire* and record 3 days of your food and beverage intake (preferably 2 weekdays and 1 weekend day).
- ✓ Fax or mail (contact information above) so that the dietitian receives at least 5 days prior to your scheduled appointment. This helps us to better prepare for your appointment as well as more efficiently utilize our consultation time together.
- ✓ Also, in order to more efficiently use our consultation time, please read our HIPAA Notice of Privacy Practices and download, print, and complete the Patient Written Acknowledgment Confirming Receipt of Notice of Privacy Practices, Authorization for Disclosure of Protected Health Information, and Consent/Release and Waiver registration documents before your first visit and bring them to your appointment with you. Forms are available at www.mooreclinic.com under the “Newsletters and Forms” section.
- ✓ In order to best meet your needs and provide you with the best possible care, please review the below practice policies.

Healthy Habitudes, LLC Practice Policies

- ✓ Payments for individual and group sessions may be made by **cash or check** payable to Healthy Habitudes, LLC. All scheduled appointments must be paid in full at the time of service. For telephone consultations, payment must be paid in advance.
- ✓ There will be a \$30.00 charge for all returned checks.
- ✓ A minimum of 24 business hours notice is required for cancellation or rescheduling of all appointments. You will be charged the full amount of your visit if do not show or do not cancel your scheduled appointment with at least 24 business hours notice.
- ✓ Packages must be used within 12 months of initial visit unless otherwise noted.
- ✓ No refunds for pre-paid follow-up visits or packages will be provided. Your appointment will be forfeited if you do not show or do not cancel your scheduled appointment with at least 24 business hours notice.
- ✓ Please respect your dietitian’s appointment time limits so that other clients are not delayed. Late arrivals will forfeit their missed time and will be charged for the full visit.
- ✓ Upon request and with a physician’s referral (including your diagnosis and your doctor’s full name), Healthy Habitudes will provide a receipt of services (a superbill) so that you may submit to your health insurance company or health savings account. Reimbursement is not guaranteed as your health insurance company or health saving account may or may not partially or fully cover nutrition services.
- ✓ Please bring copies of your most recent lab values if available to your first visit.
- ✓ For any concerns, please contact Healthy Habitudes, LLC at (803) 629-8850.



Nutrition History Questionnaire

Joey Mock, RD, LD

Phone: 803-629-8850; Fax: 1-888-412-4664; E-mail: mock8@sc.rr.com

PO Box 291960-Columbia, SC 29229

PLEASE COMPLETE AND RETURN TO DIETITIAN *BEFORE* YOUR SCHEDULED NUTRITION APPOINTMENT.

Name: _____ Date of Birth: _____

Phone Number: _____ (Home); _____ (Mobile/Work)

E-mail Address: _____ Occupation: _____

Address: _____

Reason for nutrition visit: _____

Weight History

Age: _____ Male or Female: _____ Height: _____ Present Weight: _____

1. How long have you been this weight? _____

2. Lowest adult weight: _____ (age:) Highest adult weight: _____ (age:)

3. What do you consider a good weight for yourself? _____

4. In the last year, has your weight:

Increased How much? _____

Decreased How much? _____

No change

5. How would you generally describe your eating habits?

Excellent

Good

Fair

Poor

6. If applicable, list reasons that you see are related to your overeating or overweight (example: snacking, sweets, job, depression, stress, quit smoking, fats, boredom, socializing, large portions, etc.):

7. If applicable, why do you want to lose weight? (Please check all that apply):

Appearance

Improve physical fitness

Health

Feel better

Doctor/dietitian advised

Pressure from family

Other: _____

8. Do you have people in your life who positively or negatively influence your weight goals? If so, who and how? _____

Medical Information

1. Present and past medical conditions? (Please check all that apply)

- | | | |
|--|---|--|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Elevated Triglycerides | <input type="checkbox"/> Gastrointestinal Issues |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Ulcer | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Overweight/Obesity |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cancer (Type: _____) |
| <input type="checkbox"/> Other: _____ | | |

2. Do you smoke?

- Yes If yes, how many cigarettes do you smoke each day? _____
- No

3. Rate your health:

- Excellent Good Fair Poor

4. Have you made any recent changes for improved health? _____

5. Have you checked with your doctor and received his/her O.K. to begin your nutrition and exercise program?

Medications

Please list current medications including over the counter medications.

Family History

Do you have a family history of any of the following medical conditions?

- | | | |
|--|---|--|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Gastrointestinal Issues |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Overweight/Obesity | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Other: |

Nutrition History

1. Are you now taking any vitamin and/or mineral supplements or herbal supplements?

- Yes No

If yes, please list the specific supplements and dosage that you are taking:

2. Are you now following any special diet or have you been instructed on any special diet in the past?
 Yes No

If yes, what type of diet are you following or have you been instructed on? _____

3. List the diets and/or weight loss plans that you have followed in the past.

<i>Type</i>	<i>Short-term results</i>	<i>Long-term results</i>
A.		
B.		
C.		

4. Which diet worked best? _____ Why? _____

Eating and Exercise Patterns

1. Eating patterns:

Do you regularly eat (Check all that apply)

- Breakfast Mid-afternoon snack Midnight snack
 Mid-morning snack Dinner Other _____
 Lunch Evening snack

2. Do you tend to skip meals often?

Yes No

3. What is your eating pace? Fast Slow Moderate

4. Do you usually eat: Alone With Family Other _____

5. Who usually does the cooking if you eat at home? _____

6. How many meals per week do you eat out? _____ What restaurants do you eat at most often? _____

7. Where do you eat your meals and snacks (check all that apply):

Kitchen Dining Room Bedroom
 TV room Other: _____

8. How is your appetite?

Excellent Good Fair Poor

9. Do you eat when you feel (please check all that apply):

Tense Anxious None apply to me
 Depressed Stressed Other, specify: _____
 Bored Tired

10. List any food allergies or intolerances: _____

11. List foods in which you tend to overindulge (i.e. your problem foods): _____

12. Do you drink alcohol?
 Yes No
 Amount daily (in fluid ounces): beer _____ liquor _____ wine _____
13. How many days per week do you exercise? _____ Amount in minutes per day: _____
 What type of exercise do you do? (example: walk, run, aerobics, play sports, lift weights, etc.) _____

14. How many hours per day do you watch TV, play video games, or work on a computer? _____
15. Rate your readiness to make changes?
 Not Ready Low Moderate High

Food Preparation Notes

Please complete the following regarding your eating habits.

1. What kind of cooking fat do you use (butter, olive oil, vegetable oil, etc.)? _____
2. What type of margarine/butter do you use? _____
3. What type of milk do you use (fat free, low fat, etc.)? _____
4. What cuts of meat do you purchase most often (top round, sirloin, skinless chicken breast, fish, etc.)? _____

5. What are your average meat portion sizes (3 ounces is equivalent to about the size of a deck of cards)? _____
6. Do you mainly choose regular, low fat, or fat free condiments like mayonnaise or salad dressings? _____

7. Do you eat snacks like chips, cookies, candy bars, etc.? Please specify type and how often: _____

8. How are most of your foods prepared (fried, baked, grilled, etc.)? _____
9. Other comments: _____

GOALS--What nutrition goals do you hope to achieve?

1. _____

2. _____

3. _____

Disclaimer: The consultation is provided by a Registered Dietitian (the trained expert in the nutrition field). The materials and content contained in this consultation are not intended to be a substitute for professional medical advice, diagnosis, or treatment. Participants of this consultation should not rely exclusively on information provided in the consultation for their own health needs as all specific medical questions should be presented to your own health care provider. ***If you have a medical condition, please contact your physician before making changes in your diet or exercise program.*** Participants understand that the success they achieve in this program strongly depends on their ability to make permanent changes in eating and exercise behavior. Participants are aware that the staff of Healthy Habitudes, LLC makes no claims or warranties regarding the results each participant should obtain under their direction. In consideration for your use of information from this consultation, you agree that in no event will the parties involved in creating, producing, or delivering this consultation, be liable to you in any manner whatsoever for any decision made or action or non-action taken by you in reliance upon the information provided through this consultation solely and for any injuries that may occur on the premise that the consultation takes place. Participant, personal representative, or guardian signature indicates understanding and acceptance of above disclaimer.

Signature: _____ Date: _____

(if under 18, signature of personal representative or legal guardian)

For RD Use Only:

Est. Kcal Needs: _____

Est. Fat Needs: _____

IBWR: _____

%IBW: _____

BMI: _____ **Goal Wt:** _____

Other: _____

Referring Physician: _____

Directions for Recording Your Food/Beverage Intake

- ✓ Please record all foods and beverages that you eat at meals and snacks each day for 3 days (if possible, include 2 weekdays and 1 weekend day). These 3 days should be an accurate representation of your current eating habits. Writing down what you ate immediately after each meal will ensure better accuracy. Please be as thorough and as detailed as possible when recording your foods/beverages. Include brand names, preparation method, and quantities consumed.
- ✓ Be sure to include these types of foods/beverages:

Alcoholic beverages	Coffee/Tea	Soft drinks	Cream
Butter	Margarine	Sugar/Substitute	Nuts
Jam/Jelly	Chips	Popcorn	Gravy
Dressing	Sauces	Candy	Sweets
- ✓ Don't forget to record the extras such as the tastes of food while cooking; that piece of candy that you ate out of the candy bowl at work; or the Gatorade that you drank at practice.
- ✓ Please be as accurate as possible when recording serving sizes of all the foods and beverages that you consume. If possible, choose from the following measures:

<input type="checkbox"/> Ounce	<input type="checkbox"/> Cup	<input type="checkbox"/> Teaspoon
<input type="checkbox"/> Fluid Ounce	<input type="checkbox"/> Item (such as 1 small pear)	<input type="checkbox"/> Tablespoon
- ✓ How to record portion sizes:
 - Record in ounces: All meats (3 ounces is about the size of a deck of cards)
 - Record in fluid ounces: All beverages
 - Record in cups: potatoes, rice, sliced fruits, vegetables, cereals, soups, and casseroles
($\frac{1}{4}$ cup is about the size of a golf ball; $\frac{1}{2}$ cup is about the size of a tennis ball)
 - Record in teaspoons or tablespoons (3 teaspoons = 1 tablespoon): jelly, jam, sugar, syrup, sauces, gravies, salad dressings, oils, and butter/margarine
 - Record in number and size: bread, rolls, crackers, raw fruits and vegetables, hot dogs, snack items like nuts, candy, and cookies
 - Record by slice and size: pizza, pie, cake
- ✓ Please record the meal (breakfast, snack, lunch, dinner); time; location that you ate the meal or snack (home, school, restaurant including name); specifics about the foods/beverages consumed (i.e. Orange Gatorade); and the portion size (i.e. 12 fluid ounces).
- ✓ Feel free to send or bring to your appointment food labels of any foods that you consume or that you have questions about.

