



# Pediatric Professional Nutrition Counseling

*This form must be filled out and returned to the Medical Center front desk prior to scheduling an appointment. We will contact you to schedule your initial appointment once we have received all of the necessary information.*

*Please fill out this form as completely as possible to ensure a productive first session. 24-hour notice is required to reschedule or cancel an appointment to prevent being charged the late cancellation or no-show fee.*

*If a change or cancellation is made within less than 24 hours, or if you do not show up for an appointment, you will automatically be charged a fee. This fee is \$40.00.*

\_\_\_\_\_

*I have read the above statement and understand the rescheduling protocol for my dietitian sessions.*

\_\_\_\_\_

*Signature*

\_\_\_\_\_

*Date*

## PERSONAL DATA

Name:	<input type="text"/>	DOB:	<input type="text"/>	Age:	<input type="text"/>
Address:	<input type="text"/>			Sex:	<input type="text" value="M"/> <input type="text" value="F"/>
City:	<input type="text"/>	State:	<input type="text"/>	Zip:	<input type="text"/>
Email:	<input type="text"/>	Phone:	<input type="text"/>		

## MEDICAL DATA & HISTORY

Physician's Name:	<input type="text"/>	Date of Last Physical Exam:	<input type="text"/>
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Briefly describe past & current medical history, including injuries, illness, allergies, etc:

Height  
(to closest  
1/4 inch):

Current  
Weight:

Describe any recent weight changes:

# of  
pounds:

Amount  
of Time:

List any weight management programs you have participated in:

**If you plan to use medical insurance,** please be advised that insurance providers only cover certain types of “medically necessary” appointments and require a note from your physician; please contact us for details. Also note that weight loss is usually NOT covered, even with a note from your doctor.

*\* Please bring your insurance card with you to your first appointment\**

Insurance  
Carrier:

Group #:

ID #:

If other than Microsoft Premera, please include the following from the back of your insurance card:

PO Box:

Provider  
Phone #:

Medical Diagnosis (Required if using  
insurance)

Referring  
Physician:

## FAMILY HISTORY

Briefly describe the health history of the following family members. Include history of weight loss or gain, heart disease, heart attack, diabetes, cancer, stroke, high blood pressure, high cholesterol, etc.

Mother:

Father:

Grand  
parents:

## EXERCISE

What are your physical activities?

Describe your activities and how often:

How many hours a day do you use the computer, TV, or video games?

## NUTRITION

Describe what you hope to achieve through nutrition counseling:

List all foods you are allergic to:

List any specific dietary patterns you follow (vegetarian, vegan, etc):

## SOCIAL HISTORY

How many people live in the home?

_____ Adults
_____ Children

Who cooks in the home?

Where do you grocery shop?

How often do you eat out during a typical week (breakfast, lunch and dinner)? \_\_\_\_\_

How many soft drinks do you have per week? regular: \_\_\_\_\_ diet: \_\_\_\_\_

