RougeHealth SOLUTIONS

Please complete this questionnaire except ***Section B results table***. Be as candid as possible to get the most out of your session. All information will be kept strictly confidential. Please bring the list of your medications, supplements, the last two lab results (if possible and applicable), as well as 3 day food records for the session.

Section A: Client Referral Form for Dietitian

Name: Reference number: Sex: Age: Phone:

Email: Language at home: Marital Status:

Number of Children: Education: Occupation:
student□ Part time □ full time □ shift □ casual □

1-How would you describe your job? Sedentary□ Active□

Reason for Referral:
2-Do you have any of the following nutrition-related health issues such as:
Weight gain□ pre-diabetes □ Diabetes □ Heart disease □ hypertension □ high cholesterol □ fatty liver □
gout □ anemia □ digestive issues □ constipation □ celiac □
food allergy/sensitivities □ (please explain): ____
Others (please explain): ____
____

3-Are you seeing any healthcare practitioners? Please check all that apply.

□ Medical Doctor □ Dietitian □Nutritionist □ Psychiatrist □Homeopathic Doctor
□ Massage Therapist □ Osteopath □ Herbalist □ Chiropractor
□ Chinese Medicine Practitioner □ Naturopath □ Acupuncturist □ others:

4-What was the results of your visit?
____

Physician's Name: ______________________ Physician's Phone: ______________________

5-May he/she be notified of your visit(s) □ Yes □ No

6-When is your preferred time to have a meeting with a Registered Dietitian?______________________

____

Client Name (Please print): ______________________ Signature: ______________________

Physical activities Related Questions:

7-What activities or sports are you currently involved in? ____

8-How many times a week, which day and how long do you exercise?
____

Section B: Anthropometry results *(will be filled by an assessor)*

This part will be filled by the assessor: *(please do not write in the bellow table)*

	Height:		**Age:**
Body Composition:	**Date:**	**Date:**	**Date:**
Weight:			
BMI (kg/m^2):			
IBW:			
Measurements:			
Waist (Belly Button):			
Hips:			
W/H ratio:			

Notes:____
____

Section C: CLIENT Nutritional Assessment Form

Existing Medical Conditions and Injuries:

9-Do you have any medical conditions or injuries that we need to be aware of?
____
____

10-Have you had a surgery? Please explain
____

11-Do you have family history of any diseases: Father: Mother: Siblings or others:
____

Medications:

12-Are you currently taking any medications? ___Yes ___No If so, please list the medication and for what condition.

MEDICATIONS	DURATION	REASON/CONDITION
____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________

13-Are you currently taking or have you ever taken multivitamins or any other supplements? ___Yes ___No

If yes, please List all of your current supplements (vitamins, minerals, herbs, protein, meal replacements etc)

SUPPLEMENTS	DURATION	REASON/CONDITION
____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________

Lab Results: This table will be filled by assessor *(please do not write in the bellow table)*

Date:	Date:	Date:	Date:

Lifestyle Related Questions:

14-Do you smoke? □ Yes □ No If yes, how many per day?

15-Do you drink alcohol? □ Yes □ No If yes, how many glasses per week?

16-Do you drink carbonated beverages? □ Yes □ No
If so, how many per day/week? ___ per day ___ per week

17-Do you drink Juice? □ Yes □ No
If so, how many cups per day/week? ___ per day ___ per week

18-Do you drink cow's milk? If so, how many glasses per day/week?

□ Yes □ No ___ per day ___ per week

19-Do you drink water? If so, how many glasses per day/week?
□Yes □ No ___ per day ___ per week

20-Do you drink coffee /tea? □ Yes □ No If so, how many cups per day/week?
Coffee: ___ per day ___ per week Tea:___ per day ___ per week

21-How many hours do you regularly sleep at night?

22-On a scale of 1-10, how would you rate your stress level? l(1-very low & 10-very high) :

23-List your three biggest sources of stress: ____

Nutrition Related Questions:

24-How many times a day do you usually eat (including snacks) ? ____
____

25-How often do you skip meals? ___Sometimes ___Often ___Never
26-Do you eat breakfast? ___Sometimes ___Often ___Never
27-Do you eat late at night? ___Sometimes ___Often ___Never
28-Do you eat past the point of fullness? ___Sometimes ___Often ___Never
29-Besides hunger, what other reason(s) do you eat?
___Boredom ___Social ___Stressed ___Tired ___Depressed ___Happy ___Nervous ___Other

30-Do you feel drops in your energy levels throughout the day? ___Yes ___No If yes, how many?

31-How many times per week do you eat at fast food or restaurants?

32-How often do you eat high calorie foods? ___Sometimes ___Often ___Never

33-Who normally grocery shops and cooks meals in your household? If more than one person, please explain.

34-Where do you mostly buy your groceries?(please explain)____

35-Do you have any dietary restrictions? (i.e. no meat, vegan, vegetarian, for religious/cultural reasons etc.) Please be very specific.

36-Which foods do you particularly like?

____

____

37-Which foods do you particularly dislike?

____

____

____

____

38-Please explain your weight history (stable, history of fluctuation, highest & lowest weight and your usual body weight etc.) ____

____

____

____

39-List in order of priority what nutrition goals you would most like to achieve:

Goal/Needs	Time Frame/Commitment Level
______________________	______________________
______________________	______________________
______________________	______________________

40-What barriers have prevented you from achieving these goals?

____

41-What you have done so far to achieve these goals? ____

____

____

42- On a scale of 1-10, how would you rate your commitment level to achieving your nutrition goals?
(1-very low & 10-very high):

43-What do you think is the most important thing your Dietitian can do to help you achieve your goals?

____

____

Section D: Waiver & Acknowledgement

Terms & Conditions

Please initial all the appropriate spaces indicating that you have read, understood and agree to each of the terms:

Method of Contact:

I give consent to my Dietitian to contact me via email or phone for the duration of my treatment. __________x

Rescheduling/Cancellations:

Twenty-Four (24) hours' notice is needed to cancel/reschedule your appointment. This allows the Dietitian to seek a replacement. If 24 hours' notice is not provided, the session fee will be charged to you. Thank you for your cooperation and understanding

Responsibility:

I _________________________ understand that my Dietitian is there to help guide me to reach my goals safely and efficiently. I know that I am responsible for complying with the recommendations made by my Dietitian. I am fully committed to achieving my Nutrition goals, and will do my best to adhere to the recommendations that my Dietitian and I agree upon. I will be honest with my Dietitian about my efforts in following nutritional recommendations. I understand that if I do not follow those recommendations, I may not reach my goals in the time expected. In order to benefit from the treatment prescribed by the Dietitian, I realize that it is important for me to inform my 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 Dietitian. I will not hold my Dietitian responsible for any complications that result from my failure to comply with the above terms. __________x

I acknowledge the information provided to me by the 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. _________ X

I agree to have the Dietitian keep records of our visits and to file these in a secure and appropriate place. I agree to have the Dietitian contact other healthcare professionals to benefit in my care and to share my personal information. This may be accomplished by letter, phone or fax (per PIPEDA). __________x

By submitting this form, I fully understand and agree with the terms and conditions outlined above Name (Please

Client's name: ___________________________________

Signature: ____ Date: __________________________________

Witness Name (Please Print): ____________________________________

Signature: ______________________________________ Date: __________________________________

Thank you for taking the time to complete this questionnaire