Susan Macfarlane nutrition

NEPEAN SPORTS MEDICINE & PHYSIOTHERAPY CENTRE

NUTRITION INTAKE FORM: *Please complete prior to your appointment with Susan Macfarlane, MScA, RD*

Personal Data	
Full name:	Gender:
Date of birth:	Email:
Primary phone number:	Alternate phone number:
Address:	
Physician's name:	Physician's phone number:
Physician address:	
Other healthcare professionals seen:	
Do you have insurance coverage for Registered Dietitians? Y/N	
How did you hear about Susan Macfarlane Nutrition?	
What is the reason for your visit today?	
How ready are you to make dietary/lifestyle changes (0 = not ready at all to 5 = I am very ready):	

Medical History
Current medications:
Vitamins, minerals, supplements (and respective doses):
Diagnosed medical conditions:
Surgeries and date:
Have you ever been diagnosed with a nutrient deficiency? Please describe.
Please list the relevant medical history of immediate family members (i.e. first degree relatives):

Social History/Lifestyle Habits	
Occupation:	Marital status:
Number of children (and ages):	Highest level of education obtained:
Smoke: Y/N	Illicit drug use:
Describe your weekly physical activity including the type, duration, and frequency:	
Hours spent online per day (outside of work):	
Hours of sleep per night:	Rate your sleep as good/average/poor:
Rate your stress on a scale of 1=no stress to 10= most stress you have ever experienced:	
What are the primary causes of your stress?	

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Weight History	
Are you interested in losing weight?	Weight loss goal:
Previous dieting attempts and weight loss:	
Do any first degree relatives have overweight/obesity?	
What is your lowest weight as an adult?	Age/year:
What is your highest weight as an adult?	Age/year:

Food and Nutrition History				
Food allergies or intolerances:				
Frequency of going out to eat/week:	Restaurant(s):	Reason:		
Who is responsible for cooking/grocery shopping in your home?				
Where are meals eaten?		Electronic devices present? Y/N		
Do you ever skip a meal?		Reason?		
Are you currently following a specific eating pattern (e.g. vegan, vegetarian, Mediterranean)? Please explain.				
Please bold/highlight/circle any of the following you experience on a regular basis:				
Constipation	Diarrhea	Bloating	Cramping	Distention
Gas	Altered appetite	Nausea	Vomiting	Heartburn
Dizziness	Loss of menstruation	Shortness of breath	Changes to skin, hair, nails	
Frequency at which the above symptoms occur:				

Beverage	Amount	Frequency
Water		
Coffee (regular/decaf)		
Tea (herbal/decaf)		
Cow's milk(%) or plant milk (type)		
Juice		
Regular pop		
Diet pop		
Energy drinks		
Iced tea/lemonade/sports drinks		
Alcohol		

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Please record everything you eat and drink in the table below. Include as much detail as possible, including ***what*** and ***how much*** you consumed.

	Weekday 1	Weekday 2	Weekend 1
Breakfast *Time:* *Location:*			
AM Snack *Time:* *Location:*			
Lunch *Time:* *Location:*			
PM Snack *Time:* *Location:*			
Supper *Time:* *Location:*			
Bedtime Snack *Time:* *Location:*			

Please indicate which of the following topics you would like to learn more about:

- ☐ Label reading
- ☐ Cooking
- ☐ Volumetrics
- ☐ Nutrition for active living
- ☐ Macronutrient requirements (please specify):
- ☐ Chronic disease prevention (please specify):
- ☐ Chronic disease management (please specify):
- ☐ Meal planning
- ☐ Balanced meals
- ☐ Mindful eating
- ☐ Plant-based nutrition
- ☐ Grocery shopping
- ☐ Eating at restaurants
- ☐ Vitamin/Mineral supplementation
- ☐ Gastrointestinal health
- ☐ Holiday weight management

Susan Macfarlane, MScA, RD
Registered Dietitian Nutritionist