



Mary Washington Hospital

Nutrition Counseling

4710 Spotsylvania Parkway, Suite 200
Fredericksburg, VA 22407
540.741.2210
Fax: 540.741.2077

Thank you for choosing Outpatient Nutrition Counseling Services located at Cosner's Corner Office Park. We are committed to helping you reach your health goals. Keep in mind, nutrition is not a "one-size-fits-all" approach. In your first appointment, your dietitian will review your current dietary intake, medical history, lifestyle, and physical activity to develop a sustainable plan to help you achieve your goals.

Please arrive 5-10 minutes before your appointment.

Directions and Parking:

From Route 1, turn onto Spotsylvania Parkway (turn left if heading south, turn right if heading north). Go approximately 0.4 mile. Our location will be on your right-hand side immediately after you pass Jo-Ann Fabrics and Craft Store. Look for Cosner's Corner Office Park. Come around to the front of the building. We are located in the same suite as Diabetes Management, on the second floor, turning right and right again after the elevator.

Insurance Coverage:

It is your responsibility to contact your insurance company to determine if you have the benefits to see an **outpatient dietitian** for **Medical Nutrition Therapy**. Your insurance company may require that you have pre-authorization for services. This is NOT the same as the physician order. Having a doctor's order does not guarantee insurance coverage. As a courtesy, Mary Washington Hospital will bill your insurance company. **Our fees are: \$45 per each 15-minute block.** A typical initial consult is 1 to 1¼ hour (\$180-\$225) and follow ups are usually 30-45 minutes (\$90-\$135).

What to bring to your appointment:

- Your insurance card and insurance authorization (if required)
- Blood sugar record if you are checking your blood sugar
- A spouse, friend or family member, if desired
- Completed form included with this letter

We have reserved your appointment just for you. **If you are unable to keep your appointment, please call us at least 24 hours in advance at 540.741.2210.**

Daniell McKiver
Operations Manager

Rev. 8/2024

Name/DOB: _____ Phone: _____

Email: _____ Occupation: _____

Highest level of Education Completed: _____ Marital status: _____

With whom do you live? (Include children, parents, relatives, and/or friends. Please Include ages)

Example: Sarah, age 7, sister: _____

Past Medical History: Please indicate by checkmark in LEFT column if you have/have had any of the following.

| | Illness/Disease/Symptom | Approximate Age at Diagnosis | Describe/Specify/Comments |
|--|---|-------------------------------------|----------------------------------|
| | Food Allergies/Intolerance | | Specify : |
| | Autoimmune condition | | Specify type: |
| | Cancer | | Specify type: |
| | Circulation problems | | |
| | Dental Problems | | Specify: |
| | Depression/anxiety or other mental health condition | | Specify type: |
| | Diabetes | | Specify type: |
| | Eating Disorders | | Specify type: |
| | Eye Disease/problems | | Specify: |
| | Heart Disease | | Specify type: |
| | High Blood Pressure | | |
| | High Cholesterol/Triglycerides | | |
| | Intestinal Disease | | Specify: |
| | Kidney problems | | Specify: |
| | Liver problems | | Specify: |
| | Lung problems | | Specify: |
| | Osteoporosis | | |
| | Polycystic Ovarian Syndrome | | |
| | Sleep Apnea | | |
| | Stroke | | |
| | Thyroid disease | | Specify: |
| | Other | | Specify: |

Social History:

Do you smoke, vape or chew tobacco? Never In the Past Currently, please specify type/amount/frequency: _____

Do you drink alcohol? Never In the Past Currently, please specify type/amount/frequency: _____

Do you use drugs? Never In the Past Prefer not to discuss Currently, please specify: _____

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Physical Activity: use the table below to describe your physical activity

| Activity | Type/Intensity (low/moderate/high) | # days per week | Duration |
|---|---------------------------------------|-----------------|----------|
| Cardio/Aerobics (walking, jogging, biking, etc) | | | |
| Stretching/Yoga | | | |
| Strength-training | | | |
| Sports/Leisure, Specify: | | | |
| Other, Specify: | | | |

Please specify if anything limits your ability to be more physically active: _____

On average, how many hours of sleep do you get? Weekdays _____ Weekends _____

Check which apply to you: Trouble Falling Asleep Difficulty Staying Asleep Not Feeling Rested

Indicate daily stressors and rate the level of stress from 1 (extremely low) to 10 (extremely high)

Work _____ Family _____ Social _____ Financial _____ Health _____ Other _____

How do you handle stress? What helps you relax? _____

| Vitamin, Mineral, Nutritional/Herbal Supplement Name | Dose/units | Frequency |
|--|------------|-----------|
| Ex: One-A-Day Women's multivitamin | 1000 mg | daily |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

Weight History:

Height: _____ Current Weight: _____ Highest Weight/When: _____

How do you feel about yourself at your current weight? (circle one)

Extremely Unhappy Unhappy Neutral Happy Very Happy

Please explain: _____

Have you had any recent changes in your weight that you are concerned about?

No Yes, please explain:

At what weight have you felt your best or do you think you would feel your best? _____

Were you at this weight previously, and if so when? _____

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| |
|---------------|
| Patient Label |
|---------------|

Do you feel your weight affects your daily activities (circle one)

All the time Often Seldom Not at all

Please explain: _____

Digestive History:

Do you have any digestive symptoms with eating certain foods? No Yes, please explain: _____

Please indicate how often you experience the following symptoms: (circle response)

| | | | |
|-----------------|-------|-----------|--------|
| Heartburn | Often | Sometimes | Seldom |
| Gas | Often | Sometimes | Seldom |
| Bloating | Often | Sometimes | Seldom |
| Stomach Pain | Often | Sometimes | Seldom |
| Nausea/Vomiting | Often | Sometimes | Seldom |
| Diarrhea | Often | Sometimes | Seldom |
| Constipation | Often | Sometimes | Seldom |

Diet History:

Do you follow any special diet or have diet restrictions or limitations for any reason (health, culture, religious or other)? No Yes, please describe: _____

What weight loss/fitness/lifestyle programs have you tried in the past? (circle all that apply)

Diet/Exercise on own TOPS Weight Watchers Jenny Craig NutriSystem RD/nutritionist
Physician Weight Loss Program Bariatric surgery Gym/Personal Trainer Other: _____

If you follow a special diet/nutritional program, check all that apply:

- Low Fat Low Carb High Protein Low Calorie Vegan Gluten Free
- Low Sodium Dairy Free Keto Vegetarian Other: _____

Which meals do you eat regularly, check all that apply:

- Breakfast Lunch Dinner Snacks, please list times: _____

Who prepares most of your meals at home? _____

Who shops for food for your household? _____

Yes No Within the past 12 months, I/we worried whether my food would run out before I/we got money to buy more.

Yes No Within the past 12 months, the food I/we bought just didn't last and I/we didn't have money to get more.

Based on how you eat on a regular basis, please check all that apply:

- Fast Eater Emotional Eater Late Night Overeater
- Time Constraints Often Eat "On the Go" Poor Snack Choices
- Eat Too Much Dislike Healthy Food Purchase Food From Vending Machines
- Dislike Cooking Lack Cooking Skills Eat Because I Have To
- Poor Meal Planning Rely on Convenience Foods Travel Frequently
- Drink Sweet Drinks Family Members Have Different Tastes

Frequently Eat at Restaurants, please specify which ones:

Food Cravings: _____

Food Dislikes: _____

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Briefly explain your reason for seeing the Dietitian today: _____

What do you consider to be your biggest challenges in making healthy food choices? _____

Circle the main motivators for changing your diet:

- Improve self-confidence
- Lose weight
- Increase energy level
- Improve athletic or physical performance
- Improve health (i.e. blood glucose, cholesterol levels, blood pressure)
- Prevent diseases I am at risk for: _____

On a scale of 1 (not willing) to 5 (very willing), please indicate your willingness to do the following:

| To improve your health, how ready/willing are you to.... | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|
| Significantly modify your diet | | | | | |
| Keep a record of everything you eat and drink each day for a week | | | | | |
| Modify your lifestyle (ex: work demands, sleep habits, stressors) | | | | | |
| Engage in regular exercise/physical activity | | | | | |
| Take nutritional supplements each day | | | | | |
| Have periodic lab tests to assess your progress | | | | | |

Above information has been reviewed and learning needs have been identified.

Registered Dietitian Signature

Date/Time

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