MORFIT

New Client Nutrition Assessment Form

CONTACT INFORMATION

Name: _____ Date of Birth: _____/_____/_____ Age: _____ Gender: _____

Address: _____City: _____ State: _____ Zip: _____

Daytime Phone: _____ (C)___ (W)___ (H)___ Alternate Phone: _____ (C)___ (W)___ (H)___

Emergency Contact Name and Phone: _____

Email Address (Communication, MorFit specials or other important information): _____

Note: We respect you email privacy and will NOT send spam or share your contact email with any other party

Whom do we thank for referring you/How did you hear about MorFit?_____

GENERAL INFORMAITON

Occupation: _____ Do you have children? ☐ Yes ☐ No

Age of children: _____ Marital Status _____ Are you Pregnant? ☐ Yes ☐ No Due Date: _____

With whom do you live? (Include children, parents, relatives, and/or friends. Please include ages.) Example: Sarah, Sister, 7yrs old

_____

_____

Primary Care Provider: _____ Date of last physical exam: _____

Other doctors or practitioners you see: _____

Height: _____'_____" Weight: _____ Blood Type (Please circle): A / AB / B / O / Unk

GOALS AND READINESS ASSESSMENT

I would like to visit with the dietitian today because: _____

_____

_____

My food and nutrition-relation goals are: _____

_____

_____

My overall health goals are: _____

_____

_____

If I could change three things about my health and nutritional habits, they would be:

1. _____
2. _____
3. _____

The biggest challenge(s) to reaching my nutrition goals is/are: _____

_____

_____

In the past, I have tried the following techniques, diets, behaviors, etc. to reach my nutrition goals: _____

_____

_____

_____

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

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

MEDICATION, SUPPLEMENT, AND ANTIBIOTIC INTAKE

Please provide the names of medications, supplements, and/or antibiotics that you are currently taking:

Name	**Dose**	**Frequency**	**Start Date**	**Stop Date**
Example: One-a-Day Mens Multivitamin	1200mg	Daily	2007	current

LIFESTYLE

Activity	**Type/Intensity (low-moderate-high)**	**# Days per week**	**Duration (min)**
Stretching/Yoga			
Cardio/Aerobics (walking, jogging, biking, etc.)			
Strength-training (weight-lifting, Pilates, some yoga)			
Sports or Leisure			
Other (specify/describe)			

Does anything limit you from being physically active? _____

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

- ☐ **Work** _____
- ☐ **Family** _____
- ☐ **Social** _____
- ☐ **Financial** _____
- ☐ **Health** _____
- ☐ **Other** _____

What helps you unwind? _____

On Average, how many hours of sleep do you get? Weekdays_____ Weekends_____

Do you smoke? ☐ Never ☐ In the past ☐ Currently, for how long? _____

Alcohol use? ☐ Never ☐ In the past ☐ Currently, for how long? _____

WEIGHT HISTORY

Desired Body Weight: _____ Highest Adult Weight: _____ When:_____ Weight 1 year ago: _____

Have you had any recent changes in your weight that you are concerned about? ☐ Yes ☐ No

If yes, please explain: _____

DIGESTIVE HISTORY

- Do you associate any digestive symptoms with eating certain foods? ☐ Yes ☐ No
- If yes, please explain: _____
  _____
- How often do you have a bowel movement? _____
- If you take laxatives, what type/brand and how often: _____
- Would you describe your stools as hard, soft, or loose? (circle one)
- Please indicate by circling how often you experience the following symptoms:
  Heartburn Gas Bloating Stomach Pain Nausea Vomiting Diarrhea Constipation

DIET HISTORY

Do you follow any special diet or have diet restrictions or limitations for any reason (health, cultural, religious, or other)?
☐ No ☐ Yes, _____
Please list any **food** allergies, sensitivities, or intolerances: _____
_____
_____
Who prepares the majority of your meals? _____ Who shops for the food? _____
Where do you shop for food? _____
What percentage of the foods you eat are: Whole_____% Organic_____% Convenience_____%
If you do, how much time do you spend cooking/preparing meals each day? _____
The nutrition/eating habits that are most challenging for me: _____
_____
_____
The nutrition/eating habits that I am most pleased with: _____

INTAKE INFORMATION

How often do you eat:	**Never**	**2-3x/mo.**	**1x/week**	**2-3x/week**	**1x/day**	**2-3x/day**
Fast Food						
Restaurant Food						
Vending Machine Food						
Cafeteria or Buffet food						
Frozen meals						
Home-cooked meals						
Leftovers						
Beef (hamburger, steak, etc.)						
Pork (chop, loin, ham, bacon, etc.)						
Liver						
Lamb						
Poultry (chicken, turkey, etc.)						
Deli meat, type:						
Fish, type:						
Soyfoods, type:						
Beans, type:						
Crackers, type:						
Cookies, cakes, muffins						
Whole grains, type:						
Fresh/Raw vegetables						
Cooked vegetables						
Fruit, fresh or frozen						
Canned Vegetables or Fruit						
Margarine						
Dairy (Milk, yogurt, cheese, butter)						
French Fries						
Fried meat (chicken, fish)						
Foods with added sweeteners/sugar – Type:_____						
Artificial Sweeteners – Type:_____						
Meal Replacements – Type:_____						

♦ **What are you biggest Food Cravings**: _____
♦ **List your Food Dislikes**: _____
♦ **The Food/Nutrition Questions that I would like to ask are**: _____
_____
_____
_____
_____

MORFIT
MEDICAL CENTER

Dietitian Services Consent to Treat

Ashlee Baragrey, RDN/LD provides our Dietitian Services. Ashlee is a Registered and Licensed Dietitian. She will go over your eating habits, allergies, and medical history with you, in an effort to help you improve your quality of life to its fullest. She is available for one on one sessions as well as phone sessions, including texting and emails.

Please read, sign and date on the provided lines, consenting to allow MorFit Medical to share information and billing with your insurance company. For self-pay individuals, this provides consent to collect from the patient for services rendered, both face to face and phone sessions.

Pricing for Self-Pay Sessions

15 minutes	$25.00
30 minutes (typical follow up)	$45.00
45 minutes	$70.00
60 minutes (typical first visit)	$90.00

CONSENT TO TREATMENT

I hereby request and consent to diagnostic, therapeutic procedures, and medical treatment by MorFit Medical PLLC (the "Practice"), as determined necessary in the professional medical judgement of my treating Physician and or Dietitian, including any request that I have willfully made as applicable. I am aware that the practice of medicine and related procedures is not an exact science and I acknowledge that no guarantees as to the outcome of any procedures, treatments or examinations have been made to me. I understand the following:

- Consent is given voluntarily
- I am legally competent and have the authority to provide consent for this treatment at any time
- I have the right to withdraw my consent for this treatment at any time
- Withdrawing consent for this treatment will not prejudice my continued treatment relationship

_____ _____

Patient's Signature Date

_____ _____

Printed Patient's Name Contact Phone