St George's multi therapy centre, 50 St George's Road, Bolton, BL1 2DD T: 07855 502952
www.NutritionWithDimple.com

Registered Dietitian Form **Date:** _____

Name: _____ Sex: M / F / Other Birthday: _____
DD/MM/YY

Phone number: _____ _____ _____
Home Mobile Work

May we leave messages related to your visits? Y / N

Address: _____

_____

Email address: _____

What is your occupation? _____

Doctors Name: _____ Phone: _____

Address: _____

_____

Date of last visit: _____Permission to contact your physician? Y / N

How did you hear about Nutrition With Dimple?

_____

1. Have you seen a dietitian before? If so, when and for what purpose(s)?

_____

2. What is your primary reason for seeking nutrition consultation today?

_____

Medical History

1. Please list any medical conditions (e.g. type 2 diabetes, high cholesterol, high blood pressure, etc.) and past surgeries:

2. Family Medical History: Tick items that apply for your blood relatives, including children, brothers, sisters, parents, and grandparents.

- ☐ Alcohol/Substance Abuse
- ☐ Cancer
- ☐ Diabetes
- ☐ Depression/mental illness
- ☐ Food sensitivity
- ☐ Stroke
- ☐ Heart disease
- ☐ High blood pressure
- ☐ Hyperlipidaemia (high cholesterol)
- ☐ Obesity
- ☐ Smoking
- ☐ Thyroid dysfunction

3. Personal Medical History: Tick problems you have or had that have been diagnosed by a physician or other health professional.

- ☐ Alcohol/Substance Abuse
- ☐ Anaemia
- ☐ Food sensitivity
- ☐ Lactose intolerance
- ☐ Other allergies
- ☐ Arthritis
- ☐ Cancer
- ☐ Diabetes
- ☐ Heart attack or stroke
- ☐ High blood pressure
- ☐ Hyperlipidaemia
- ☐ Chewing difficulties
- ☐ Gallbladder disorder
- ☐ Gout
- ☐ Gastrointestinal trouble
- ☐ Constipation
- ☐ Frequent Diarrhoea
- ☐ Obesity
- ☐ Eating disorder
- ☐ Sleeping problems
- ☐ Ulcer
- ☐ Limitations on activity
- ☐ Other: _____ _____

Seeing, hearing, other impairment:_____

4. Please list all medications, vitamins and supplements that you are currently taking:

Name of medication	Dosage	Frequency	Purpose

5. Do you have any food allergies or intolerances?

_____

6. Do you have any dietary restrictions (religious, vegan or vegetarian, etc.)?

_____

Anthropometrics

1. Height: _____ Current weight: _____

2. Have you lost or gained weight recently? If so, how much?

_____

Habits

1. Do you drink alcohol? Y / N
2. Smoking:
   - ☐ Smoke cigarettes — # cigarettes per day_____
   - ☐ Smoke pipe/cigar
   - ☐ Quit smoking in past year
   - ☐ Non-smoker

3. Regular Exercise (including on the job): ☐ Yes ☐ No
   # times per week _____
   # minutes per session _____
   Describe:_____
   _____
   _____

Limitations on Activity: Describe_____
_____
_____

4. How often in a week do you eat out?

_____

5. In your household, who does the most grocery shopping?
   Who does the most cooking?

_____ _____

I certify that the information provided on this form is accurate to the best of my knowledge. By completing this form and booking an initial nutrition consultation, it is implied that I consent for the Registered Dietitian to use my personal information for the purposes of nutrition assessment and development of treatment plans. I also consent to allow staff at Nutrition With Dimple to use my personal information for administrative purposes.

_____ _____
Client Signature Date