

Bluegrass Nutrition Counseling Screening Form

Appt Date/Time _____

Referred by: _____

Personal Information

Name: _____ Sex: _____ Age: _____ Birthdate: _____

Email: _____ (ok for our use only ?) circle Yes/No

Address (include City, State, Zip Code): _____

Phone: Home _____ Work _____ Cell _____

Best way to reach you: please circle Home Number, Work Number, Cell Number, Email

Height: _____ Weight: _____ Recent Weight Change? _____ If so, how much? _____

Goal Weight: _____

Occupation: _____ Employer: _____

Primary Nutrition Problem/Concern: _____

Other Medical Problem(s): _____

Pertinent Family History: _____

Medications/Supplements: _____

Allergies: _____ Current Exercise Program: _____

Current Diet: _____

Guardian Name: _____ Address: _____

Phone: Home: _____ Work: _____ Cell: _____

Insurance Information

Primary Insurance: _____ Policy/Group #: _____

Address: _____ Telephone: _____

Name of Insured: _____ Address: _____ Phone: _____

Birthdate: _____ Employer: _____ Phone: _____

I authorize the release of any medical or other information necessary to process any claims. In the event that my insurance company will not cover nutrition services, I will be responsible for payment.

Signature

Date

For Dietitian's Use Only

Activity Level: Strenuous (1.6) Moderate (1.5) Light (1.4) Sedentary (1.3)

Estimated Needs:

BEE _____ x Activity _____ x Stress _____ = _____ kcals
0.8 g/kg = _____ protein (g)/day

BMI = _____