Mary Washington Hospital
MWHC

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.

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. 3/2024

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:_____
_____

Patient Label

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?_____

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 <u>regular</u> 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:_____

Patient Label

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