Mary Washington Healthcare

Nutrition Counseling
4710 Spotsylvania Parkway, Suite 200
Fredericksburg, VA 22407
540.741.2227 or 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: $40 per each 15-minute block.** A typical initial consult is 1 to 1¼ hour ($160-$200) and follow ups are usually 30-45 minutes ($80-$120).

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.**

Cathy Peterjohn, MS, RD, CDE
Manager

Rev. 08/2018

Name: _____ Date of Birth: _____

Phone: _____ Email: _____

Height: _____ Usual Weight: _____

Occupation: _____ Highest Level of Education Completed: _____

How many people live in your home and what is your relationship to them? _____

What are you hoping the dietitian can help you achieve? _____

_____

Please indicate if you have or have had any of the following:

Disease/Condition	Yes/No	Comments
Diabetes	Yes/No	If yes, when was it diagnosed?
Heart Disease	Yes/No	
High Blood Pressure	Yes/No	
High Cholesterol/Triglycerides	Yes/No	
Cancer	Yes/No	
Intestinal Problems	Yes/No	
Depression/Anxiety/Other Mental Health Condition	Yes/No	Please specify:
Kidney problems	Yes/No	
Liver problems	Yes/No	
Eye problems	Yes/No	
Stroke	Yes/No	
Circulation problems	Yes/No	
Sleep apnea	Yes/No	
Food allergies/intolerance	Yes/No	
Dental problems	Yes/No	
Eating Disorder	Yes/No	

Please list any nutritional/herbal supplements (or you may attach a list):

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Do you smoke? ____ If yes, how much? _____

Do you drink alcohol? ____ If yes, what type and how much? _____

Do you exercise regularly? ____ If yes, what type and how often? _____

Do you have any exercise restrictions? ____ If yes, what are they? _____

NS4030

Mary Washington Healthcare

Medical Nutrition Therapy Intake Form

PATIENT IDENTIFICATION

1 1/4" X 3"

Who does the grocery shopping for your household? _____

Who does the food preparation ? _____

Which restaurants do you visit most often? _____

What do you consider to be the most challenging part of making healthy food choices? _____

_____

_____

Please circle the most appropriate response to rate your <u>TYPICAL</u> eating habits:

Eating Habits/Behaviors		**Comments**
Do you skip meals?	**Y N**	
Do you snack?	**Y N**	How many times/day?
Do you buy your lunches?	**Y N**	
Do you eat out daily?	**Y N**	
Do you eat fast food?	**Y N**	
Do you order take out?	**Y N**	
Do you read food labels?	**Y N**	If yes, what do you look for?
Do you eat in the car?	**Y N**	
Do you eat in front of the TV?	**Y N**	
Do you eat with others most of the time?	**Y N**	
Do you eat when you aren't hungry?	**Y N**	
Are you an emotional eater?	**Y N**	
Do you avoid certain foods?	**Y N**	Please list:
Are you a binge eater?	**Y N**	

Mark the response below that best describes your current intentions for adopting good nutrition and dietary habits.

1. I am not planning to adopt any new nutrition or dietary habits this year.
2. I'm planning to start making improvements in my nutrition and dietary habits in the next six months.
3. I'm planning to start making improvements in my nutrition and dietary habits in the next 30 days.
4. I've adopted good nutrition and dietary habits and I've maintained them for less than 6 months.
5. I've adopted good nutrition and dietary habits and maintained them for more than 6 months.

_____ _____

Registered Dietitian Date/Time

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