Sandi Williams, M. Ed., RD, CDE
Registered Dietitian and Certified Diabetes Educator

Nutrition Profile Fax/Email Back

1407 Yonge Street, Suite 406
Toronto, Ontario M4T 1Y7
E-mail sandi@sandiwilliams.com **Phone/Fax: 416-924-9119**

IMPORTANT: PLEASE READ

PAYMENT OPTIONS

1) Reminder: This service is not covered by OHIP.
2) Many private health insurance carriers cover dietitian services. Check with your insurance provider for details. If your provider doesn't cover the services of a "Registered Dietitian", ask **WHY NOT**??
3) Payment is due on the first visit. Cash, Cheque or VISA are accepted. A receipt will be issued at the end of your package of visits.

CANCELLATION/MISSED APPOINTMENT POLICY:

1) Please provide 24 hours notice if you need to change your appointment. This will allow other clients to be booked into your time slot.
2) Missed follow up appointments will be treated as a visit spent.
3) All banked visits must be used within six months of purchase unless previously arranged.

It is not uncommon for client's to cancel their visit when they are not doing well on their plan. This is a time when you need to see your Nutrition Coach to help you through the tough spot. Do not cancel for this reason! You are hiring a private coach to help you achieve your nutrition and healthy lifestyle goals.

CONGRATUALATIONS! You have made the first step toward reaching your goals, by making this appointment. I look forward to working with you.

Sincerely,

Sandi

Sandi Williams, M. Ed., RD, CDE

Please fax or email back your completed forms at least one day prior to your appointment FAX# 416-924-9119 or sandi@sandiwilliams.com. If you have questions, please email or call 416-924-9119

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Registered Dietitian and Diabetes Educator

Office Fee Policy – Please Sign

The services of a Registered Dietitian are not covered by the Ontario Health Insurance Plan (OHIP). Some private insurance carriers do cover some of the cost. Check with your private insurance carrier for details. Fees are due when the service is rendered. Insurance coverage is a contract between you and the insurance company. You are responsible for submitting costs to the insurance company.

Weight Loss/General Nutrition

Initial Assessment and 3 Follow up visits	**$425.00**

Follow up packages

4 visits	**$180.00**

If you have to cancel:

1. **To allow other clients to be booked into your time slot, 48 hours notice is required.**
2. **If you do not provide 48 hours notice for a follow up appointment it will be treated as a visit and deducted from your account.**

ALL BANKED VISITS MUST BE USED WITHIN SIX MONTHS OF PURCHASE UNLESS PREVIOUSLY ARRANGED.

If you have any concerns related to the above, please discuss them with Sandi on or before your first visit.

I have read and understand the above:

Date_____

Signature_____

Are You Ready to Make a Lifestyle Change?

Before embarking on a lifestyle change program, ask yourself the following questions.

1) Compared to previous attempts, how motivated are you to lose weight/change your eating habits at this time? Very Motivated_____, Somewhat Motivated _____

2) Is there something about this time that is likely to make you successful? Yes_____ No_____

3) Consider all outside factors at this time in your life (the stress you're feeling at work, your family obligations, etc.) Are you determined to put in the effort required to stick to a program? Can you see yourself cooking healthy meals and exercising one year from now? Yes_____ No_____

4) Think honestly about how much weight you hope to lose and how quickly you hope to lose it. A weight loss of one to two pounds per week is a healthy weight loss, how realistic is your expectation? Realistic_____ Unrealtistic_____Not applicable _____

5) Are you prepared to include exercise into your daily/weekly schedule? Yes_____ No_____

6) Are you willing to give up some foods in an effort to lose weight, control your diabetes, manage your cholesterol etc? Yes_____ No_____

7) Do you have supportive friends, coworkers and/or family who will support you in your efforts? Yes_____, No_____

8) Do you eat when you are stressed, anxious, lonely or bored? Yes____ No_____
If yes, are you prepared to look for other strategies to manage these occasions? Yes____, No_____

9) Do you binge eat? Do you use laxatives, or induce vomiting. Yes_____, No____
These are symptoms of several eating disorders.

If you answered positively to questions 1-7 you are likely readily to make a lifestyle change.
If you answered yes to questions 8 & 9, you may need to seek counselling to manage these problems prior to starting a weight loss plan.

If after answering these questions you feel the time is right for you to make a lifestyle change, please answer the following questionnaire. If you are in doubt, you may call Sandi to discuss your concerns.

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CONFIDENTIAL CLIENT QUESTIONNAIRE – GENERAL ASSESSMENT FORM

GENERAL INFORMATION

NAME_____ **MD NAME**_____

ADDRESS_____ **MD ADDRESS**_____

_____ _____

HOME PHONE_____ **PHONE**_____

WORK_____ **DATE OF LAST PHYSICAL**_____

CELL _____ **HOW DID YOU HEAR ABOUT THIS SERVICE?**

EMAIL_____ _____

PERSONAL NUTRITION AND LIFESTYLE GOALS and/or REASON FOR REFERRAL

_____

_____

_____

HEALTH HISTORY

FAMILY HISTORY **Please indicate health problems that have occurred in your family**

DIABETES - WHO_____ **DIET**_____**DIET AND PILLS**_____ **INSULIN**_____

CARDIOVASCULAR DISEASE (Heart Attack/Stroke) – WHO?_____**AGE**_____

HIGH CHOLESTEROL – WHO?_____ **HIGH BLOOD PRESSURE – WHO?** _____

CANCER – WHO?_____ **OSTEOPOROSIS -** _____

YOUR PERSONAL HEALTH HISTORY **DATE OF BIRTH**_____**AGE**_____

HIGH CHOLESTEROL - LAB VALUES please try to obtain recent lab results from your MD

TOTAL CHOL_____ **TRIGLYCERIDES**_____**LDL**_____**HDL**_____ **TOTALCHOL/HDL**_____

HIGH BLOOD PRESSURE ___ **HEART ATTACK** ____ **ANGINA** _____ **STROKE** ____ **DATE**_____

Health History continued

PAST HOSPITALIZATIONS?_____

HYPOGLYCEMIA _____

GASTRO INTESTINAL COMPLAINTS_____

OSTEOPOROSIS _____ **MENOPAUSE COMPLAINTS**_____

OTHER_____

MEDICATIONS_____

SUPPLEMENTS/VITAMINS_____

LIFESTYLE INFORMATION

OCCUPATION_____ **HOURS AT WORK**_____

BUSINESS TRAVEL? _____ **HOW OFTEN?** _____

 # IN YOUR HOUSEHOLD _____**PERSON RESPONSIBLE FOR COOKING**_____ **SHOPPING**_____

HOW MANY TIMES/WEEK DO YOU EAT OUT FOR :

BREAKFAST_____, **LUNCH** _____, **DINNER**_____, **FAST FOODS?** _____/**week**

HOW MANY OFTEN DO YOU GROCERY SHOP?____/**WEEK HOW OFTEN DO YOU COOK FOR YOURSELF**____/**WEEK**

ALCOHOL # DRINKS/week_____ **wine**_____/**week beer** _____/**week liquor**_____/**week**

PHYSICAL ACTIVITY: TYPE_____

HOW OFTEN?_____**FOR HOW LONG?**_____

HOW MANY HOURS OF SLEEP DO YOU GET EACH NIGHT?_____

SMOKING? / AMOUNT_____ **HAVE YOU TRIED TO QUIT?**____**PLANS TO QUIT?**_____

WEIGHT HISTORY

***RD will complete**

HEIGHT_____ **inches**_____ ***cm. WEIGHT** _____ **lbs.** _____***kg. BMI***_____

Weight 1 year ago_____**5 years ago**_____**10 years ago**_____**Goal Weight?**_____ **BMI***_____

Previous Diets?_____

_____

Success_____

Food Frequency

Please indicate how often you eat the foods listed below. For example; if you eat beef three times per week then simply mark 3 in the "Week" column and leave the other columns blank. If you never eat a certain food then just "X" the "Never" column.

	HOW OFTEN?					
FOOD	**Day**	**Week**	**Month**	**Year**	**Never**	**DIETITIAN'S USE ONLY**
Example: **Beef**		**3**				
Beef						
Pork						
Lamb						
Poultry						
Fish						
Shellfish						
Organ meat (liver kidney etc.)						
Cold cuts / sliced meats						
Hot dogs						
Sausage/Bacon						
Eggs						
Cheese						
Nuts/PB						
Seeds						
Beans, lentils, chickpeas						
Tofu / tempeh						
Soy milk						
Milk: __Homo ___2%___1% ____skim						
Cream						
Yogurt						
Ice Cream / Frozen dessert						
Cakes & Pies						
Cookies						
Chocolate bars/Candy						

FOOD	Day	Week	Month	Year	Never	DIETITIAN'S USE ONLY
Cold Cereal						
Hot cereal (oatmeal etc.)						
Pasta /Rice						
Potatoes						
French fries						
Crackers						
Bread / Pita						
Muffins/bagels						
Donuts/ Danish Croissant						
Fresh fruit						
Salad/Raw Veg						
Cooked Veg						
Margarine/Butter						
Cream cheese						
Oil						
Gravy/Sauces						
Salad dressing						
Olives						
Mayonnaise						
Table salt						
Soup						
Coconut milk						
Potato chips						
Fruit juice						
Soda pop – regular / diet						
Coffee / Tea						
Wine						
Beer						
Liquor						

Do you have foods that you would call "problem foods"? Please list

Food Record

Keep track of all foods eaten for three days on the following sheets. Record the foods as you eat them. Try to be as specific as possible, Example: 2 cups pasta with 1 cup tomato meat sauce, 2 TBSP parmesan, Salad, with ¼ cup salad dressing (Ranch), 2 x 7 oz glasses red wine, 24 grapes and 3 x 2" Chocolate chip cookies.

Date		**Food Record Day 1**
Time	**Amount**	**Food Eaten**
Morning meal		
Snack		
Afternoon Meal		
Snack		
Dinner		
Snack		

Date		Food Record Day 2
Time **Morning meal** **Snack** **Afternoon Meal** **Snack** **Dinner** **Snack**	**Amount**	**Food Eaten**

Date		Food Record Day 3
Time **Morning meal** **Snack** **Afternoon Meal** **Snack** **Dinner** **Snack**	**Amount**	**Food Eaten**

Sandi Williams Nutrition and Diabetes Counselling

1407 Yonge St Suite 406
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1 Block south of St. Clair
Subway exit via Yonge and St Clair (south exit Pleasant Blvd)
Green P parking available on Pleasant Blvd

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