244 Manchester Way
Middletown, DE 19709
Tel (302)897-2088
Fax (302)376-9261

TKS Nutrition, LLC
Healthy Habits for Life
tksnutrition@verizon.net
www.tksnutritionllc.com

Patient Registration

(Please print clearly)

Patient name: First	Middle	Last			Home Phone #:	
E-mail address:		Social Security #:			Cell Phone #:	
Home Address:		City:			State:	Zip Code:
Occupation:	Marital Status:	Date of Birth:			Age:	Gender:
Spouse (or parent) name: First	Middle	Last			Date of Birth:	
Family Physician:	Address:		Phone #:			
Referred By:	Address:		Phone #:			

Billing and Insurance Information

PRIMARY INSURANCE	Insurance Company Name:		Policy #:	Group/ Plan Code:
	Subscriber's Name:		Date Effective:	
	Subscriber's Date of Birth:	Gender:	Home Phone #:	Relationship to Patient:

Do you have any other Insurance? YES NO (If YES, Please provide details below)
Insurance Company Name: _____ Policy #: _____
Group/ Plan Code: _____ Date Effective: _____
Subscriber's Name: _____ Date of Birth: _____Relationship to Patient: _____

A message (please check a box): □ can □ can not be left on my home phone. Initial:____

By signing below you are indicating all above information is accurate to the best of your knowledge.

Patient Signature: _____ Date: _____

Read each question carefully. Complete or fill in the circle of the best answer from the choices given. Then go to the question specified after your response. Thank you.

1. How many years of education have you completed?

_____ Number of years between 3 and 24.

2. What is your current or previous occupation?

_____

2a. Mark the one that applies best:

① Full-time
② Part-time
③ Not working/retired

2b. Mark if doing shift work ○ Shift work

3. In the last five years, what was your highest weight? _____ (lbs)

4. What was your lowest weight? _____ (lbs)

5. What is your desired weight? _____ (lbs)

6. What is your current weight? _____ (lbs)

7. What is your height without shoes? ____ (in)

8. Family history Select any of the following health problems found in your immediate family (parent, brother, sister).

① colorectal cancer
① breast cancer
① ovarian cancer
① prostate cancer
① high blood pressure
① high cholesterol
① osteoporosis
① diabetes
① stroke
① coronary heart disease, heart attack, or coronary surgery before age 55 in men, or before 65 in women
① I don't know my family history

9. Are you living alone?

① Yes [skip to question 10], if no, mark the general health status of those you live with.

1. Spouse - ① Good ② Fair ③ Poor
2. Partner ① Good ② Fair ③ Poor
3. Infant – (< 1 year) ① Good ② Fair ③ Poor
4. Son(s) – (child < 13) ① Good ② Fair ③ Poor
5. Son(s) – (teen 13-20) ① Good ② Fair ③ Poor
6. Son(s) – (adult 20+) ① Good ② Fair ③ Poor
7. Daughter(s) – (child < 13) ① Good ② Fair ③Poor
8. Daughter(s) (teen 13-20) ① Good ② Fair ③ Poor
9. Daughter(s) – (adult 20+) ① Good ② Fair ③ Poor
10. Other(s) ① Good ② Fair ③ Poor

10. Personal history Do you have any of the following conditions? Mark all that apply.

① allergies
① anxiety disorder
① sleep disorder
① emphysema (COPD)
① heart disease
① migraine headaches
① depression
① osteoporosis
① pregnant (women)
① arthritis _____
① List other (if any) _____

① high blood pressure
① asthma or bronchitis
① diabetes
① high cholesterol
① back pain
① skin cancer
① other cancer
① gout
① kidney disease

_____

11. Medications currently taking, dose and frequency

Medication	Dose	Frequency

1. Do you have any dietary preferences (such as eating vegetarian) or some restriction (such as a food allergy) that may limit your food choices?

① Yes [please mark list below], if no please skip to question 2.

Preferences

Please indicate the dietary restriction(s) or preference(s) below. Mark all that apply to you.

① **a** - Strict Vegetarian or Vegan – will not eat any animal products such as meat, poultry, seafood, milk (milk products) or eggs.

① **b** - Lacto-ovo vegetarian – will not eat animal product such as meat, poultry or seafood but will eat eggs and milk products such as yogurt and cheese.

① **c** - Other vegetarian – will not eat most animal products but will eat some.

① **d** - Medical restriction – have a medical condition where my doctor has limited certain foods or has given me a special therapeutic diet.

e - List name of condition(s) here

_____

① **f** - Milk intolerance – have a milk allergy and avoid many or all milk products.

①**g** – Food allergies:_____

The following questions are about your eating habits and the specific foods you eat. Before you answer these questions, it may be easier if you first write down everything you ate in the last 24 hours. Or, keep a food diary for three days, recording everything you eat and drink, noting the time of day and the specific amounts. These activities will prepare you to answer the following questions most accurately.

2. On most days, how many meals do you eat?

_____ per day **2a**. Snacks? _____ per day

3. How many of those meals are usually prepared by you or someone in your household?

_____ per day

4. How many meals per **week** do you usually eat out? Count meals prepared by a commercial food service, restaurant, deli or fast food provider.

_____ per week

Breakfast: _____ Lunch:_____ Dinner: _____

5. Breakfast - How often do you eat breakfast?
① everyday
② most days
③ some days
④ rarely or never

6. Skip meals - How often do you skip a meal?
① everyday
② most days
③ some days
④ rarely or never

7. Night eating - How often do you eat a meal or snack less than 2 hours before bedtime?
① everyday
② most days
③ some days
④ rarely or never

8. Appetite – How do you rate your appetite or desire for food?
① very good
② good
③ not always good
④ poor most of the time

9. Satisfied - How often do you stop eating after you feel you have eaten enough?
① always
② most of the time
③ some of the time
④ rarely or never

10. Binging, is to lose control by eating a large amount of food over a short period of time. Do you ever binge?

① Yes, if no, skip to question 12.

11. How many times per week?

_____ per week

12. Water - Think about what you drink all during the day. How many cups (8 oz cup) of water or other non-caffienated beverages such as juice do you have on most days (do not count tea, coffee, beer or other alcoholic beverages)?

_____ per day

13. How many **caffeinated beverages** do you drink each day? Please include regular tea, coffee, espressos, lattes, or caffeinated soft drinks.
_____ per day

14. Alcohol - Have you had any alcoholic beverages in the last 6 months?

① Yes [go to question 15], if no, skip to 16.

15. How many drinks of beer, wine or Liquor do you regularly have per **week**? (one drink is 3 to 5 oz. wine, 10 oz wine cooler, 12 oz beer or 1.5 oz liquor)

_____ drinks per week

16. Milk preferences - Which statement best describes the fat content of milk you would choose to drink?

① Only regular whole milk (about 4% fat)
② Both regular whole milk and low fat milk
③ Only low-fat milk (1 to 2 % fat)
④ Both low-fat and non-fat milk
⑤ Only non-fat milk (0.5% fat)
⑥ Do not drink dairy milk
⑦ Do not drink dairy milk but use fortified dairy alternates such as 1% soy, rice or almond milk

17. Fat preferences - When choosing foods for your meal, do you usually select, high-fat or low-fat foods? After reviewing the examples, select the most appropriate response.

High-fat examples: hamburgers, sausages, luncheon meat, marbled beef, sour cream, cheese, eggs, butter, pastry, ice cream, full-fat dairy products, chocolate, fried foods and many fast foods

Low-fat examples: lean meats, skinless poultry, fish, low-fat dairy products, fruit desserts, gelatin, vegetables, pasta, and legumes (peas and beans)

① choose high-fat foods nearly all the time
② choose high-fat foods most of the time
③ choose both high and low-fat foods equally as often
④ choose low-fat foods most of the time
⑤ choose low-fat foods all the time

18. Added salt - How often do you add salt to your food?

① not at all
② occasionally (2 – 3 times per week)
③ moderately (one meal per day)
④ quite often (nearly every meal)
⑤ Majority of the time (on most everything)

19. Salty food - How often do you eat salty foods (such as soy sauce, pickles, canned meats, salted nuts or potato or corn chips)?

① not at all
② occasionally
③ moderately
④ quite often
⑤ majority of the time

20. Fiber preferences How often do you choose to eat high-fiber foods such as whole wheat bread or pasta, high-fiber breakfast cereal and brown rice?

① rarely or never
② occasionally
③ sometimes
④ majority of the time
⑤ always

22. Supplements - Do you take vitamin pills such as vitamin C, calcium, or other nutrient supplements on a typical day?

① Yes, if no, skip to the next section.

List supplements – If you are taking supplements, list them below.

_____
_____
_____
_____
_____
_____

Physical Activity and Other

1. Judge your current activity level. Think about how active you are on most days. Consider the following definitions.

> **Rest**: Sleeping or reclining.
>
> **Very light activity**: Seated at a desk or standing activities, painting trades, driving, laboratory work, typing, sewing, ironing, cooking, playing cards, playing a musical instrument.
>
> **Light activity**: Walking on a level surface at 2.5 to 3 mp, garage work, electrical trades, carpentry, restaurant trades, house cleaning, childcare, golf, sailing, or table tennis.
>
> **Moderate activity**: Walking 3.5 to 4 mph, weeding and hoeing, carrying a load, cycling, tennis, or dancing.
>
> **Heavy activity**: Walking with a load uphill, tree felling, heavy manual digging, field hockey, climbing, playing soccer or football.

Select the choice below that best describes your activity during a typical day?

① **Very Light**: 10 hours of rest and 14 hours of very light activity.
② **Light**: 10 hours of rest and 14 hours of only light activity.
③ **Moderately active**: 10 hours of rest and 14 hours of light and/or moderate activity
④ **Very active**: 10 of rest and 14 hours of moderate and heavy activity.
⑤ **Vigorously active:** 10 hours of rest and 14 hours of heavy activity.

2. - How much time do you spend in **moderate** (walking, easy cycling, swimming, active gardening, gym workouts) or **vigorous** (jogging, running, active sports, heavy labor) physical activity **each week**?

① I am **not** physically active on a regular basis.
② I do **moderate** activities for **less than** 30 minutes at a time, on **some (1-3) days** of the week.
③ I do **moderate** activities for **less than** 30 minutes at a time, on **most (4-7) days** of the week.
④ I do **moderate** activities for at least 30 minutes at a time, on **some (1-3) days** of the week.
⑤ I do **moderate** activities for at least 30 minutes at a time, on **most (4-7) days** of the week.
⑥ I do **vigorous** activities for 30 minutes or more at a time, on **at least 3 days** of the week.

3. Exercise restrictions – Has a doctor every told you to restrict or limit physical activity or exercise?

① Yes, if no, skip to next question.

4. Screen Time – which includes TV, computer, video gaming & texting

① Less than 30 minutes daily
② Between 30 minutes – 1 hour daily
③ Between 1-2 hours daily
④ Greater than 2 hours daily

5. Smoking – Do you smoke cigarettes every day?

① yes [go to question 6], if no, skip to 7.

6. How many cigarettes do you smoke a day?

_____ per day

7. Other tobacco – Do you use other tobacco?

① Yes; if no, skip to next question

Readiness to Change

7. Good nutrition and dietary habits include eating a balanced diet from a variety of wholesome foods. This involves eating appropriate amounts from each food group and avoiding excess fat, alcohol or calories.

Mark the response below that best describes your current intentions to adopt **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 maintained them for less than 6 months.

⑤ I've adopted good nutrition and dietary habits and maintained them for more than 6 months.

Food History

Please **complete** the "Food Frequency" and a "3 day Food Intake". The information will be used to evaluate your normal meal patterns, types of foods/ beverages you select daily, how much food/ beverages you usually consume daily and how your food/ beverages are prepared. Please return your "Food Frequency" and "3 Day Food Intake" reports at least 3 days prior to your scheduled appointment.

How many times **per day** do you eat or drink the following foods/ beverages?				
Bread: whole wheat or white	Cereal:	Chips/ Pretzels:	Crackers:	Pasta/ Rice: White or whole wheat/ brown
Fruit:	Fruit Juice:	Vegetables:	Vegetable Juice:	Water:
Milk (Cow's, Soy, Rice):	Yogurt:	Cheese:	Red meat:	Fish:
Chicken/ Turkey:	Tofu:	Nuts/Beans:	Eggs:	Peanut Butter:
Beer/Wine/Mixed Drinks:	Sweets:	Sweetened beverages (tea, sports drinks, sweetened juice drinks)	Soda:	

Please record three days of your food/beverage intake including type of food, how it was prepared and portion size and activity below.

Day and Time	Day 1	Day 2	Day 3
Breakfast Food/beverages & amount			
Snack Food/beverages & amount			
Lunch Food/beverages & amount			
Snack Food/beverages & amount			
Dinner Food/beverages & amount			
Snack Food/beverages & amount			
Exercise: what you did and how long			