Scripps Whittier Diabetes Institute
La Jolla Main Line: (858) 626-5672/ Fax (858) 626-7111
Rancho Bernardo (858) 605-7369/ Fax (858) 605-7292
Vista (760) 806-5863 / Fax (760) 806-5429

PLEASE PLACE PATIENT LABEL HERE OR FILL OUT

Patient Name: _____

MRN: _____

NUTRITION COUNSELING QUESTIONNAIRE

Patient Goal/Reason for visit: _____

MEDICAL HISTORY

☐ Heart Disease ☐ Depression
☐ Stroke ☐ Alcohol/Drug Abuse
☐ High Blood Pressure ☐ Low Thyroid
☐ High Cholesterol ☐ Gestational Diabetes
☐ High Blood Sugar ☐ Other_____

FAMILY HISTORY

☐ Diabetes ☐ Heart Disease
☐ Obesity ☐ High Cholesterol
☐ High Blood Pressure ☐ Other_____

MEDICATIONS:

_____
_____
_____

SUPPLEMENT/HERBS/VITAMINS:(Current Use)

_____
_____
_____

Do you have any problems with any of the following? (check box)

☐ Constipation ☐ Diarrhea
☐ Nausea ☐ Allergies
☐ Heartburn ☐ Gas
☐ Food Intolerance (Which food?) _____

Eating Behavior

Do you eat when you are: (check if applicable)

☐ Hungry ☐ Depressed ☐ Tired
☐ Alone ☐ Angry ☐ In need of reward
☐ Bored ☐ Happy ☐ Relaxing in front of TV
☐ Other (specify): _____

Do you exercise? (Last 12 months) ☐ Yes ☐ No
How often? _____
Type of exercise? _____
How long? _____

Physical Data:

Height _____ Weight _____

Weight one year ago _____

Desired Weight _____

Usual Adult Weight _____

List a typical day of what you eat (amount)

Breakfast	**Time**	**Beverage**
Snack(s)	**Time**	**Beverage**
Lunch	**Time**	**Beverage**
Snack(s)	**Time**	**Beverage**
Dinner	**Time**	**Beverage**
Snack(s)	**Time**	**Beverage**

Do you drink alcohol? ☐ Yes ☐ No
Type and amount: _____

FOOD PREPARATION

Who does your cooking? _____
How often do you eat fast food? _____
How often do you eat from restaurants?
(include take-out) _____

How is your food cooked?

☐ Bake ☐ BBQ ☐ Boil ☐ Breaded
☐ Broil ☐ Fry ☐ Roast ☐ Microwave

Have you ever followed a special diet? ☐ Yes ☐ No
What type of diet did you follow?
_____

How long did you follow it? _____
Why was the diet prescribed? _____
Was the diet successful? _____

Scripps Whittier Nutrition Program

Dr. Name _____

FAX: _____

Diagnosis: _____

PLEASE PLACE PATIENT LABEL HERE OR FILL OUT

Patient Name: _____

MRN: _____

Educator Use Only:

Ht: _____ Wt: _____ Pt. Wt. Goal: _____ BMI: _____

ASSESSMENT	*Concept*	*Education*	*Understood*
☐ Inadequate exercise or physical activity	☐ Basic Nutrition	**Y / N**	**Y / N**
☐ Moderately high/high fat intake	☐ Meal Timing	**Y / N**	**Y / N**
☐ Low complex CHO	☐ Label Reading	**Y / N**	**Y / N**
☐ High sodium	☐ Food Preparation/Meal Planning	**Y / N**	**Y / N**
☐ Erratic, unscheduled eating	☐ Dining Out	**Y / N**	**Y / N**
☐ Limited support	☐ Exercise	**Y / N**	**Y / N**
☐ Poor dining out choices	☐ Fat	**Y / N**	**Y / N**
☐ Emotion/Stress-related eating	☐ Fiber	**Y / N**	**Y / N**
☐ Lack of meal planning	☐ Sodium	**Y / N**	**Y / N**
☐ Insufficient intake of_____	☐ Supplements	**Y / N**	**Y / N**
☐ Excess intake of _____	☐ Behavioral Aspects	**Y / N**	**Y / N**
☐ Other: _____			

PROGRESS NOTE/PLAN OF CARE

Specific nutrition education recommendations given to your patient include:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

	Time	B	S	L	S	D	S
CHO grams							
Starch							
Fruit							
Milk							
Veg.							
Protein							
Fat							

Follow-up _____ Weeks _____ Months _____ Time spent w/pt:_____

Visit Provider Signature: _____

Date: _____

◆ *The Whittier Institute for Diabetes*
La Jolla (858) 626-5672
◆ *Scripps Clinic*
Del Mar
◆ *Scripps Coastal*
Vista

◆ *Scripps Mercy*
Hillcrest
◆ *Scripps Clinic*
Encinitas

◆ *Scripps Clinic*
Rancho Bernardo
◆ *Scripps Clinic*
Rancho San Diego

Scripps Whittier Institute