KANODIA MD
MEDICINE MADE SIMPLE

***Please send via fax or scan 24 hours before your nutrition appointment
Fax: 614-524-5829***

Nutrition New Patient Intake Form* **Date:** _____

We do recommend that you bring a family member, or friend, who can help support you throughout your health journey.

Please allow 20-30 minutes to answer as completely as possible. This will enhance your ability to reach your health goals (**The nutrition Cancellation Policy is the same as the Kanodia MD policy. Refer to page 4 for specifics).

General Information

Name:	**Preferred Name:**
Best Way to Reach You?	

Complaints/Concerns

What do you hope to achieve in your visit?

Please list your three main nutritional concerns:

1.	
2.	
3.	

The biggest Challenge(s) to reaching my nutrition goals is/are?

In terms of food…

What makes you feel better?	
What makes you feel worse?	
Any additional comments:	

Allergy Information (i.e. reactions that occur right away such as lip/throat/tongue swelling, difficulty breathing, rash etc.)

Please list food allergies	
What type of allergic symptoms do you experience?	
List any food sensitivities or intolerances	

*Adapted from University of Maryland Faculty Physicians, INC and KU Integrative Medicine

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Readiness Assessment
In order to improve your health, how willing are you to: *Very willing* *Not Willing*

Significantly modify your diet	☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1
Take several nutritional supplements each day	☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1
Keep a record of everything you eat for a specific amount of time	☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1
Modify your lifestyle (e.g., work demands, sleep habits, exercise)	☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1
Have periodic nutrition lab tests to assess your progress	☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1

How much on-going support and contact (e.g., telephone, e-mail) from the Dietitian would be helpful to you as you implement your personal health program? (i.e. daily, weekly, every 2 weeks, monthly)

Oral Health History
Do you have any ☐ Tooth pain ☐ Bleeding gums ☐ Gingivitis ☐ Chewing problems

Lifestyle Information

Activity	**Type/Intensity** (low-moderate-high)	**# Days/Week**	**Duration** (minutes)
Stretching/Yoga			
Cardio/Aerobics			
Strength Training			
Sports or Leisure (walking)			

Rate your level of motivation for including exercise in your life? ☐ Low ☐ Med ☐ High

After exercise do you feel worse? *Yes or No*

Lifestyle Information (continued) *Circle Yes or No*

Is there excess stress in your life? *Yes or No*

Do you easily handle stress? *Yes or No*

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Daily Stressors: ***Which of these options cause stress in your life?***

☐ Work ☐ Family ☐ Social ☐ Finances ☐ Health ☐ Other:

Do you wake up during the night? ☐ Y ☐ N If yes, how many times?	Do you believe stress is presently reducing the quality of your life? ☐ Y ☐ N
Average number of hours you sleep per night during the week?	Average number of hours you sleep per night on weekends?
Trouble falling asleep ☐ Y ☐ N	Rested upon waking? ☐ Y ☐ N

How would you rate the overall quality of your sleep? *low quality* 1 2 3 4 5 *high quality*

Additional Nutrition history

Have you ever had a functional medicine nutrition consultation? ☐ Y ☐ N

Please describe any special diet or nutrition program you have used in the past:

__ Commercialized weight loss program (i.e. Weight Watchers, Jenny Craig, Medifast, etc.)

Name of the program:_____dates:_____ successful: Y / N / NA

Name of the program:_____dates:_____ successful: Y / N / NA

Name of the program:_____dates:_____ successful: Y / N / NA

Diet or nutrition programs that you have done- Check all that apply:

___Vegan	___Low OR High Fat	___Allergy Free	___Paleo	___Anti-Inflammatory Diet
___Vegetarian	___Low or High Carb	___Dairy Free	___Ketogenic Diet	___Low- Glycemic Load
___Pescatarian	___Low or High Protein	___Lactose Free	___Elimination Diet	___Detox Program
		___Gluten Free	___South Beach Diet	___Atkins Diet

____Other (please specify)

Current Eating Habits

How many meals and snacks do you typically eat per day? ____

Dining out (fast-food, restaurant, cafeteria, snack bar, etc.)

Number of meals:_____per day / week (please circle one)

Typically consumed for: ___breakfast ___lunch ____dinner ___ snack

Do you **avoid** any particular foods? Y / N

Do you **crave** any particular foods? Y / N

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Digestion
How often do you have a bowel movement? _____
Describe your typical stool consistency: ____hard ___soft ____loose __well-formed __alternate loose/hard

Check all the factors that apply to your current lifestyle and eating habits:

	Late night eating		Emotional/ stress eating
	Fast Eater		Dislike "healthy" food
	Overeating		Yo-yo dieting
	Live/ Eat alone		Poor meal planning
	Skipping meals		Over- sized portions
	Binge eating		Crave carbs/ sweets
	Erratic eating patterns		Time constraints
	Rely on convenience food items		Travel Frequently
	Love to eat		Eat because "I have to"
	Other:		

Please note anything additional about your nutrition/eating habits: *(If you need more space please use back)*
***To get the most out of your nutrition appointment please send this packet 24 hours in advance via fax or scan.*

Thank you for taking the time to complete this questionnaire.
This will be a valuable guide for us to achieve your health goals!
Lauren Arnett, RDN, LD

Cancellation Policy: In order to stay on time and provide the most comprehensive care for our patients, we request that you arrive 10 minutes early for your appointment to allow time for check in.
****We require that ALL PATIENTS give us a 2 business day notice if you are unable to keep an appointment, so that we may open it up to another patient**.
****If scheduled as a new patient a credit card will be taken at the time of scheduling and if you cancel within 2 business days you will be charged in full.**
(For example, if you cannot come to your Monday 1 pm appointment, you would call us by Thursday 1 pm.)

For Follow Up Appointments:
Less than 2 Business Days/NO Show Policy:

- 1st NO SHOW/Late/Cancellation (less than 2 business days) patient pays half of the office visit. (Payment must be made before patient can be rescheduled)
- 2nd NO SHOW/Late/Cancellation (less than 2 business days) patient pays full office visit. (Payment must be made before patient can be rescheduled)
- 3rd NO SHOW/Late/Cancellation (less than 2 business days) patient is dismissed from the practice.

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You may disregard this page if you previously filled one out. You can also use an app such as MyFitness Pal to record your meals

Food Log Day #1

Date:_____

**Include meals and snacks as complete & detailed as possible.

Meal/Snack Time of day	Food/ Beverage	Notes (feelings, hunger etc.)
Sample- Breakfast 8:30a.m.	Coffee, eggs, spinach and avocado	Felt full, but started feeling bloated

Physical activity type & amount:

Summary of the Day:

Food Log Day #2

Date:_____

**Include meals and snacks as complete & detailed as possible.

Meal/Snack Time of day	Food/ Beverage	Notes (feelings, hunger etc.)
Sample- Breakfast 8:30a.m.	Coffee, eggs, spinach and avocado	Felt full, add variety of vegetables next time

Physical activity type & amount:

Summary of the Day: