

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

**Nutrition Profile Fax Back**

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FAX: 416-924-9119

E-mail [sandi@sandiwilliams.com](mailto:sandi@sandiwilliams.com)

Phone: 416-924-9119

**IMPORTANT: PLEASE READ**

**PAYMENT OPTIONS**

- 1) This service is not covered by OHIP.
- 2) Many private health insurance carriers cover dietitian services. Check with your insurance provider for details.
- 3) Payment is due on the first visit. Cash, Cheque or VISA are accepted. A receipt will be issued.

**CANCELLATION/MISSED APPOINTMENT POLICY:**

- 1) Please provide 24 hours notice if you need to change your appointment. This will allow us to rebook other clients into your time slot. A \$50.00 cancellation fee will be billed if you do not provide the required cancellation notice.
- 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.

***Please fax back your completed forms at least one day prior to your appointment (FAX# 416-924-9119). If you have questions, please call.***

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

**Office Fee Policy**

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	<b>\$400.00</b>
<b>Follow up packages</b>	
4 visits	<b>\$180.00</b>

**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\_\_\_\_\_ Unrealistic\_\_\_\_\_
- 5) Are you prepared to work 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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**Registered Dietitian and Certified Diabetes Educator**

**CONFIDENTIAL CLIENT ASSESSMENT QUESTIONNAIRE**

**GENERAL INFORMATION**

NAME _____	MD NAME _____
ADDRESS _____	MD ADDRESS _____
_____	_____
_____	_____
HOME PHONE _____	PHONE _____
WORK _____	DATE OF LAST PHYSICAL _____
FAX _____	HOW DID YOU HEAR ABOUT THIS SERVICE? _____
EMAIL _____	_____

**PERSONAL NUTRITION AND DIET GOALS and/or REASON FOR REFERRAL**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**HEALTH HISTORY**

**FAMILY HISTORY** 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 - \_\_\_\_\_

**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

DIABETES \_\_\_\_\_ – managed by? - DIET \_\_\_\_\_ DIET AND PILLS \_\_\_\_\_

INSULIN \_\_\_\_\_ BLOOD SUGAR MONITORING –Please bring results

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

ALCOHOL # DRINKS/week \_\_\_\_\_ wine \_\_\_\_\_/week beer \_\_\_\_\_/week liquor \_\_\_\_\_/week

PHYSICAL ACTIVITY: TYPE \_\_\_\_\_

HOW OFTEN? \_\_\_\_\_ FOR HOW LONG? \_\_\_\_\_

SMOKER / 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.

FOOD	HOW OFTEN?					DIETITIAN'S USE ONLY
	Day	Week	Month	Year	Never	
<i>Example:</i> 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**

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## 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 Morning meal	Amount	Food Eaten
Snack		
Afternoon Meal		
Snack		
Dinner		
Snack		

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

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

## Sandi Williams Nutrition and Diabetes Consulting

1407 Yonge St Suite 504  
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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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