



**WebNutri.com consulting, LLC**  
*Your Health Comes First*

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**If possible, please Fax or Email the completed form 24 hours prior to your scheduled appointment time. If you are planning to fill out this form at the time of your office visit, please arrive 15 minutes prior to your scheduled appointment time. If you have any questions please ask your Dietitian.**

**REGISTRATION FORM**

**Personal Information**

Today's Date: \_\_\_ / \_\_\_ / \_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_ / \_\_\_ / \_\_\_ (MM/DD/YY) Age: \_\_\_\_\_

Gender:  M  F Occupation: \_\_\_\_\_

How were you referred to us?  Website  Friend  Physician  Advertisement  Other

What is the reason for your visit? \_\_\_\_\_

Have you ever worked with a Registered Dietitian in the past?  Yes  No

How would you like us to contact you? (Check all that apply)

Home Address  Home Phone  Mobile Phone  Email  Other: \_\_\_\_\_

May we leave a message?  Yes  No

Email address: \_\_\_\_\_

Phone (home): \_\_\_\_\_ Phone (mobile): \_\_\_\_\_

Home Address: \_\_\_\_\_ Apt #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Emergency Contact Name & Phone: \_\_\_\_\_

Please list anyone you wish to give full access to your personal health information (include relation, name, and phone number) \_\_\_\_\_

Do you have difficulty reading?  Yes  No

**Physician Information**

Physician's name (primary): \_\_\_\_\_ Specialty: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Website: \_\_\_\_\_

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Did your physician refer you to a dietitian?  Yes  No

May we contact this physician with updates on your progress?  Yes  No

### Medical History Diagnoses/Medical Conditions (check all that apply):

- |  |  |  |  |
|--|--|--|--|
| <input type="checkbox"/> Digestive disorders         | <input type="checkbox"/> Diabetes                | <input type="checkbox"/> Depression                        | <input type="checkbox"/> Acid Reflux           |
| <input type="checkbox"/> Osteoporosis                | <input type="checkbox"/> Liver disease           | <input type="checkbox"/> Kidney disease                    | <input type="checkbox"/> Anemia                |
| <input type="checkbox"/> Gallstones                  | <input type="checkbox"/> Gestational<br>Diabetes | <input type="checkbox"/> Nausea                            | <input type="checkbox"/> Vomiting              |
| <input type="checkbox"/> Alteration in taste         | <input type="checkbox"/> Constipation            | <input type="checkbox"/> Hypertension                      | <input type="checkbox"/> High cholesterol      |
| <input type="checkbox"/> Fatigue                     | <input type="checkbox"/> Cancer                  | <input type="checkbox"/> High Triglycerides                | <input type="checkbox"/> Gout                  |
| <input type="checkbox"/> Heart disease               | <input type="checkbox"/> Celiac Disease          | <input type="checkbox"/> Skin problems                     | <input type="checkbox"/> Chronic Pain          |
| <input type="checkbox"/> Bulimia                     | <input type="checkbox"/> Parkinson's             | <input type="checkbox"/> PCOS                              | <input type="checkbox"/> Multiple Sclerosis    |
| <input type="checkbox"/> Diarrhea                    | <input type="checkbox"/> Colitis                 | <input type="checkbox"/> Binge Eating                      | <input type="checkbox"/> Anorexia              |
| <input type="checkbox"/> Congestive heart<br>failure | <input type="checkbox"/> Disordered<br>Eating    | <input type="checkbox"/> Diverticulitis/<br>Diverticulosis | <input type="checkbox"/> Metabolic<br>Syndrome |
| <input type="checkbox"/> Thyroid disease             | <input type="checkbox"/> Stomach ulcers          | <input type="checkbox"/> Mental illness                    | <input type="checkbox"/> Mental Retardation    |
| <input type="checkbox"/> Drug Addiction              | <input type="checkbox"/> Alcoholism              | <input type="checkbox"/> Seizure Asthma                    | <input type="checkbox"/> Wounds                |
| <input type="checkbox"/> Chronic UTI                 | <input type="checkbox"/> Kidney stones           | <input type="checkbox"/> Unplanned weight loss             | <input type="checkbox"/> Weight gain           |
| <input type="checkbox"/> Glaucoma                    | <input type="checkbox"/> Goiter                  | <input type="checkbox"/> HIV/AIDS                          | <input type="checkbox"/> Hair loss             |
| <input type="checkbox"/> Colostomy                   | <input type="checkbox"/> Excessive Thirst        | <input type="checkbox"/> GI bleeding                       | <input type="checkbox"/> Malnutrition          |
| <input type="checkbox"/> Feeding Tube                | <input type="checkbox"/> Excessive Hunger        | <input type="checkbox"/> Bleeding Gums                     |  |

### Women Only (check all that apply):

- |  |   |  |   |
|--|---|--|---|
| <input type="checkbox"/> Chronic Yeast<br>Infections | <input type="checkbox"/> Trying to become<br>pregnant | <input type="checkbox"/> Pregnant<br>_____ Months                | <input type="checkbox"/> Menopause<br>Age : _____ |
| <input type="checkbox"/> Menstrual<br>Irregularities | <input type="checkbox"/> Endometriosis                | <input type="checkbox"/> Endometriosis<br>Fibroids/Ovarian Cysts | <input type="checkbox"/> PMS                      |
| <input type="checkbox"/> Breast Cancer               | <input type="checkbox"/> Ovarian Cancer               | <input type="checkbox"/> Breast Feeding                          | <input type="checkbox"/> Infertility              |

### Men Only (check all that apply):

- |  |  |
|--|--|
| <input type="checkbox"/> Prostate Cancer | <input type="checkbox"/> Testicular Cancer |
|--|--|

**List all Prescription Medications:** \_\_\_\_\_  
\_\_\_\_\_

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### Health History

Do you use artificial sweeteners?

Aspartame  Saccharin  Splenda \_\_\_\_\_ times per  Day  Week  Month

Caffeine?  Coffee  Tea  Carbonated Beverages \_\_\_\_\_ times per  Day  Week  Month

Tobacco?  Cigarettes  Cigars  Smokeless Tobacco \_\_\_\_\_ # per  Day  Week  Month

If you quit smoking, for how long did you smoke? \_\_\_\_\_ Years Date of last tobacco product: \_\_\_/\_\_\_/\_\_\_

Do you drink Alcohol?  Beer  Wine  Liquor \_\_\_\_\_ drinks per  Day  Week  Month

Do you have difficulty chewing?  Y  N Do you have difficulty swallowing?  Y  N

Do you have mouth pain?  Y  N

Do you wear dentures?  Y  N  Uppers  Lower  Partial Do they fit well?  Y  N

### Known Lab Values:

Sodium \_\_\_\_\_ Potassium \_\_\_\_\_ Glucose \_\_\_\_\_ A1c \_\_\_\_\_ TSH \_\_\_\_\_

Cholesterol \_\_\_\_\_ Triglycerides \_\_\_\_\_ BUN \_\_\_\_\_ Creatinine \_\_\_\_\_

Prealbumin \_\_\_\_\_ Albumin \_\_\_\_\_ Hematocrit \_\_\_\_\_ Hemoglobin \_\_\_\_\_

Other: \_\_\_\_\_

### Weight History

Height: \_\_\_\_\_ feet \_\_\_\_\_ inches

Weight (pounds) \_\_\_\_\_

Do you feel your weight is:  Too High  Too Low  Healthy  Not Sure

Weight 6 months ago: \_\_\_\_\_ Highest weight since age 18: \_\_\_\_\_ Lowest weight since age 18: \_\_\_\_\_

Current weight trend:  Gaining  Losing  Stable

The weight change is  Intentional  Unintentional

Is your goal to:  Lose Weight  Gain Weight  Maintain Weight

Personal Goal Weight: \_\_\_\_\_

How soon do you expect to reach your weight goal? \_\_\_\_\_ Years \_\_\_\_\_ Months \_\_\_\_\_ Weeks \_\_\_\_\_ Days

### Diet History

Have you ever felt your eating was out of control?  Y  N

Do you have trouble keeping food down?  Y  N

Have you ever been treated for disordered eating?  Y  N

Are you working with a therapist?  Y  N Have you ever worked with a therapist?  Y  N

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If yes, please list the therapist's name: \_\_\_\_\_

Which meals do you have daily?  Breakfast  Lunch  Dinner  Snacks

Do you skip meals sometimes?  Breakfast  Lunch  Dinner  Snacks

What types of foods do you typically eat?

Made from scratch  Fast Food  Convenience  Restaurants

How often do you eat out? \_\_\_\_\_ times per day \_\_\_\_\_ times per week \_\_\_\_\_ times per month

What methods have you tried in the past to reach your weight/health goals? (check all that apply)

- Low-Fat Diets  Fasting  Low-Carb Diets  Low-Calorie Diets  
 Meal Replacements  Bariatric Surgery  Herbs  Chiropractic  
 Acupuncture  Weight Loss Pills  Exercise  Hypnosis  
 The Zone Diet  Colonics  Low Glycemic Index Diets  Weight Watchers

Other: \_\_\_\_\_

What supplements are you currently using:  Multivitamin  Vitamin C  Vitamin E  Vitamin D

Acidophilus  Digestive Enzymes  Omega-3 (fish oils)  CoQ10  Protein Powders

List all other nutritional supplements/products: \_\_\_\_\_

Current Diet Restrictions:  Salt  Vegetarian  Carbohydrates  Fat

Protein  Gluten  Nuts, Seeds, Hulls  Other: \_\_\_\_\_

Food Allergies/Intolerances: \_\_\_\_\_

Religious/Cultural Food Preferences: \_\_\_\_\_

How many servings of the following do you consume daily?

Fruits  1  2  3  4  5 or more Vegetables  1  2  3  4  5 or more

Dairy  1  2  3 or more Beans/Lentils  1  2  3 or more

Meat (ounces)  1  2  3  4  5  6 Nuts & Seeds  1  2  3 or more

Poultry (ounces)  1  2  3  4  5  6 Fish (ounces)  1  2  3  4  5  6

Whole Grains  1  2  3  4  5  6  7  8  9  10  11  12 or more

### Exercise History

Has your physician restricted you from doing any physical activity?  Y  N

If yes, what restrictions? \_\_\_\_\_

Do you experience any of the following during exercise?

Shortness of Breath  Lightheadedness  Leg Cramps  Stomach Cramps  Chest Pain

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Nausea                       Back Pain                       Joint Pain                       Irregular heart beat

How often do you exercise? \_\_\_\_\_ minutes per day \_\_\_\_\_ days per week

Types of activities (check all that apply):

Strength Training (weights)     Cardio                       Aerobics                       Pilates  
 Yoga                       Running                       Walking                       Swimming                       Cycling                       Competitive Sports  
 Tennis                       Golf                       Hiking                       Skiing                       Other: \_\_\_\_\_

How would you classify your activity?

Sedentary (little or no activity)                       Light (light activity active for 30-60 min 2-3 days per week)  
 Moderate (active 30-60 min  4-5 days /wk)                       Heavy (vigorous activity > 1 hour 6-7 days/wk)

I acknowledge that the health information stated above is the best according to my knowledge.

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**Client or Representative Signature**

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**Date**

I acknowledge receiving a copy of the **Professional Disclosure Statement** (available on our website [www.webnutri.com](http://www.webnutri.com) or attached with the clip board). By your signature below, you are indicating that you have read and understood this statement, and that any questions you have had about this statement have been answered to your satisfaction. By my signature, I verify the accuracy of this statement and acknowledge my commitment to conform to its specifications.

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**Client or Representative Signature**

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**Date**

Notice of Policies

1. Payment is due at the end of the session. Cash, Credit Card, or Check is accepted. Please make **checks payable to Webnutri.com consulting**. A \$30 fee will be charges for all returned check.
2. Cancellations must be made **by phone 24 hours before** the scheduled appointment so that we can schedule other clients for this time. No shows or cancellations NOT made within the 24 hour period will be billed at the full rate.
3. Overdue payments must be paid before future appointments are scheduled. Late fees of 25% will be charged after 60 days. At this time, we will send your account to collections.
4. Some insurance companies cover services from a Registered Dietitian. We will provide you with a receipt called a "superbill" so that you can submit it to your insurance company for reimbursement.
5. Packages must be used within 9 months of purchase, and no rebates or refunds will be given.
6. We reserve the right to choose alternate meeting locations if safety concerns are identified.
7. The last 5 minutes of each appointment is used for scheduling and business matters.

I have read and understand the policies noted above.

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**Client or Representative Signature**

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**Date**