SAMARA FELESKY-HUNT
REGISTERED DIETITIAN AND NUTRITIONIST
& ASSOCIATES

The Downtown Sports Clinics - Barclay Centre
#250, 444 7th Avenue SW
Calgary, AB
T2P 0X8
Phone: 403-233-7007

NUTRITION CONSULTING

SAMARA FELESKY-HUNT, BSc., RD, Registered Dietitian

Name:_____ Referred By:_____

Address:_____ City:_____

Postal Code:_____ Email:_____
(*for communication purposes relating to your treatment or for confirmation of appointment*):

Telephone: Residence:_____Work:_____ Cell:_____

Birth Date:_____ Age:_____ Gender:_____ Type of Employment:_____

Family Physician:_____

Medications:_____

Supplements:(Vitamins/ Minerals/ Herbs/ Protein):_____

_____

Personal Health History:

Asthma__	Osteoporosis__	Eating Disorder__
Diabetes__	Irritable Bowel __	Hypertension__
Cardiovascular Disease__	Arthritis__	Diverticulosis__
Colitis/Crohns/Celiac__	Cancer__	High Cholesterol__
Depression/Anxiety__	Migraines__	Ulcers/GERD/Reflux__
Hypoglycemia__	Hyper/Hypothyroid__	Gall/Kidney Stones__

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Allergies__(please list)_____

Other:_____

Family Health History

Cancer__ Diabetes__ Osteoporosis__
Cardiovascular Disease__ Stroke__ Other_____

Please indicate any symptoms you may have or occasionally suffer from:

Prolonged Fatigue__ Constipation__ PMS__ Acne__
Gas/Indigestion__ Headaches__ Peri/Menopausal Symptoms__
Sinus Pain__ Eczema__ Canker/Cold Sores__
Colds/Flu/Coughs__ Bloating__ Diarrhea__

Please check those factors you consider to be essential for you to achieve optimal health:

Assessment of nutritional intake__ Incorporating healthy meal ideas__
Improving eating habits__ Assessing food intolerances__
Decreasing body fat levels __ Motivation, support & encouragement__
Increasing lean body mass__ Other comments:_____

How would you rate your present energy level? Poor__ Normal __ High __
Describe your personal weight history in the last 5 years:_____
_____

How many hours a night do you sleep?_____
On a scale 1 to 5, what would your current "stress level" be: 1-lowest, 5-highest:_____
Are you physically active now? Yes__ No__
List activities and frequency_____
_____

Do you snack in the evening? Yes__ No__
Do you have any cravings for salt, sugar or carbohydrates? Yes__ No__
How many 6 oz /1 cups of water do you drink per day? ____
Have you seen a registered dietitian, nutritionist or naturopath before? Yes__ No__

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Are you on any specific diet? Yes__ No__
How do you feel a registered dietitian can assist you today? _____

Billing Note*: *Payment for services is required after appointments with our dietitian.

I, _____, acknowledge and understand I am liable for all
(print name)

costs incurred by me for nutrition consulting services received at THE Downtown Sports

Clinics. Signature:_____ Date: _____

Many health insurance care providers and extended health insurance plans may cover registered dietitian services. Please check your provider for a full/or partial reimbursement. Thank you