



Filomena Vernace-Inserra, BAsc, RD

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Congratulations on recognizing the need to change how you choose to live each day! Whether it is to eat healthier, lower your body weight, or address health concerns such as elevated blood pressure, blood sugar, or cholesterol, this program will assist you to make the necessary changes to achieve a healthier you!

You have embarked on one of the most important journeys of your life! Addressing dietary and lifestyle habits to achieve improved health and well-being is no easy task. One that many cannot embark on alone! The nutritional counseling that you will receive will be tailored to meet your specific needs, address your specific concerns, one step at a time & at a pace that is respectful to you.

As a Registered Dietitian with close to 30 years of patient counseling experience, I look forward to joining you on this journey towards better health and vitality. To assist me in guiding our counseling sessions, please complete the attached **Nutrition Questionnaire**. Included here is a **3-day food record** which will ask you to record everything you eat and drink for 3 days prior to the scheduled nutrition appointment. Also, please complete the mandatory **Consent Form** prior to the appointment. This can also be downloaded from my website.

When completing the questionnaire, or documenting your food intake, answer honestly and maintain your usual eating habits. Please be as detailed as possible when listing your food intake for each of the 3 days. Be sure to document what you eat and drink as you consume these foods and beverages for increased accuracy.

As a reminder, private nutrition counselling sessions are **not** covered by OHIP. Some private extended health care plans do cover nutrition counselling fees. Contact your representative to find out if you are eligible. Fees are payable when services are rendered. Official receipts will be issued accordingly.

Your initial assessment visit is 1 hour in length and subsequent follow-up visits are ½ hour. In the event of a cancellation, you are requested to contact the Dietitian via telephone or email **24 hours prior** to the scheduled appointment. A late cancellation fee of \$30 may be imposed.

Please remember to bring the completed **Nutrition Questionnaire & Consent Form** with you to your appointment. I look forward to joining you on this important journey of change to a healthier you.

Filomena

Vaughan Office

Columbus Medical Building
8333 Weston Rd (just south of Langstaff)
4th floor, Suite 405

Virtual Counselling

Provincial boundaries - Ontario

PERSONAL INFORMATION

- DO YOU CONSENT TO EMAIL/PHONE COMMUNICATIONS WITH FILOMENA?
 WOULD YOU LIKE TO BE ADDED TO OUR COMPLIMENTARY NUTRITION NEWSLETTER?

NAME: _____

<p>Address: _____ _____</p> <p>Email address: _____</p>	<p>Phone Number: _____</p> <p>Work Number: _____</p> <p>Cell Number: _____</p>
<p>Family Physician: _____</p> <p>Phone Number: _____</p> <p>Referring Physician: (if different from family physician) _____</p>	<p>Do you consent to the Dietitian contacting the referring physician for additional information such as bloodwork results or medications pertaining to your nutritional care:</p> <p><input type="radio"/> Yes, I give consent to Filomena contacting my referring physician to obtain more medical information that pertains directly to my nutritional care</p> <p><input type="radio"/> No, I do not give consent</p>
<p>Age: _____</p> <p>Date of Birth: (dd/mm/yy) _____</p>	<p>Family Medical History (parents, siblings):</p> <p><input type="checkbox"/> Cardiovascular <input type="checkbox"/> Diabetes <input type="checkbox"/> Other <input type="checkbox"/> Cancer <input type="checkbox"/> Weight</p>
<p>Medical History: (please check all that apply)</p> <p><input type="radio"/> Food Allergies: _____</p> <p><input type="radio"/> Food Intolerances: _____</p> <p><input type="radio"/> Elevated blood cholesterol/heart problems</p> <p><input type="radio"/> Elevated blood pressure</p> <p><input type="radio"/> Elevated blood sugar/Diabetes</p> <p><input type="radio"/> Gastrointestinal disorders/discomfort</p> <p><input type="radio"/> Liver/Kidney (specify): _____</p> <p><input type="radio"/> Neurologic (ie.mental health)</p> <p><input type="radio"/> Thyroid disorder</p> <p><input type="radio"/> Bone/Joint problems</p> <p><input type="radio"/> Surgeries: _____</p> <p><input type="radio"/> Other: _____</p>	<p>Medications & Nutritional Supplements: _____ _____ _____ _____</p> <p>Have You Received Previous Nutrition Counselling?</p> <p><input type="radio"/> No <input type="radio"/> Yes, if yes answer the following:</p> <p>Where and in what setting did you receive the nutrition counselling:</p> <p>Where: <input type="radio"/> hospital setting <input type="radio"/> community centre <input type="radio"/> private <input type="radio"/> other: _____</p> <p>How: <input type="radio"/> individual <input type="radio"/> group</p>

FOOD RECORD FORMS - DAY #1

Workday? Yes No N/A

Name: _____

Date: _____

Meal/Time (am/pm)	Food/Beverage Description (one item per line)	Portion Size (quantity)	At Home/Restaurant
<i>Example</i>			
7am	<i>Bran cereal</i>	<i>1 cup</i>	<i>Home</i>

Is this a typical day? Yes No
 If no, please explain why: _____

FOOD RECORD FORMS - DAY #2

Is This A Workday? Yes No N/A

Name: _____

Date: _____

Meal/Time (am/pm)	Food/Beverage Description (one item per line)	Portion Size (quantity)	At Home/Restaurant
Example 7am	Bran cereal	1 cup	Home

Is this a typical day? Yes No
If no, please explain why: _____

FOOD RECORD FORMS - DAY #3

Is This A Workday? Yes No N/A

Name: _____

Date: _____

Meal/Time (am/pm)	Food/Beverage Description (one item per line)	Portion Size (quantity)	At Home/Restaurant
<i>Example</i>			
<i>7am</i>	<i>Bran cereal</i>	<i>1 cup</i>	<i>Home</i>

Is this a typical day? ___Yes ___No
If no, please explain why: _____