

# Weight Management and Metabolic Care

1783 Route 9, Suite 101 • Clifton Park, NY 12065  
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 Christina Santiago, FNP-BC • Tiffany Schermerhorn, AGACNP-BC • Ali Watson, Pharm.D., BCACP

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

24-Hour Diet Recall- Please record all meals, snacks, and beverages consumed. Include portion sizes when possible.

Time	Food	Portion Size	Notes
Breakfast			
Snack			
Lunch			
Snack			
Dinner			
Evening Snack			

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## Beverage Intake

Please record approximate daily amounts:

- Water (oz/day): \_\_\_\_\_
- Caffeine (coffee, tea, energy drinks) (oz/day): \_\_\_\_\_
- Alcohol (oz/day): \_\_\_\_\_
- Juice (oz/day): \_\_\_\_\_
- Soda (regular or diet) (oz/day): \_\_\_\_\_
- Milk (oz/day): \_\_\_\_\_

## Food Allergies & Intolerances

- List any known food allergies: \_\_\_\_\_
- List any food intolerances or sensitivities: \_\_\_\_\_

Supplements taken daily: \_\_\_\_\_

## Social History

Please describe:

- Occupation / Work schedule: \_\_\_\_\_
  - Living situation (alone, family, roommates): \_\_\_\_\_
  - Who does the grocery shopping?: \_\_\_\_\_
  - Who prepares meals?: \_\_\_\_\_
  - Previous attempts at weight loss (ie WW, Noom, diet and exercise): \_\_\_\_\_
- \_\_\_\_\_

## Current Struggles or Barriers

What challenges make it difficult to meet your nutrition or weight-related goals?

(Examples: time constraints, cost, cravings, emotional eating, limited support, pain, mobility, etc.)

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