**NUTRITION COUNSELING CLIENT CONTACT FORM**

**Name: DOB:**

**Date of Visit:**

**Ht: Wt: Ideal Body Wt: Age:**

**Health History**:

**Medications:**

**Determination of Risk:**.

**Dietary Recall:**

**Visit Summary:**.

**Nutrition Counseling:**

**Guided the client in setting the following goals:**

**Spent \_\_\_\_\_minutes Counseling Client**

**\_\_\_\_\_\_\_\_\_\_, RDN**