

MEDICALLY SUPERVISED DIET AND EXERCISE PROGRAM

Each bolded section must be completed otherwise the form will be considered incomplete.

Patient Name: _____ **Date of Visit:** _____

Date of Birth: _____ **Visit Number:** _____

Patient VS: Blood Pressure: _____ **Temp:** _____

Patient is following a:

- 1200 ca/day diet
- 1500 cal/day diet
- 2000 cal/day diet
- Weight Watchers Program
- Nutrisystem diet
- Jenny Craig
- Other: _____

Patient participates in exercise:

- 0-2 times per week
- 3-4 times per week
- 5-7 times per week
- Patient is unable to exercise due to: _____

Patient is participating in the following exercise regimen:

- Walking
- Yoga/Pilates
- Swimming
- Aerobics
- Curves
- Gym/Club membership
- Water aerobics
- Physical therapy
- DVD/Video tapes
- Other: _____

Co-morbidities: _____

Current medications: _____

Height: _____ Weight: _____ BMI: _____

Check all that apply:

- Change in weight since last visit +/- _____ lbs
- Change in body mass since last visit +/- _____ %
- Patient verbalized understanding of carbohydrates, fats, and protein grams
- Patient keeps a food journal
- Patient keeps an exercise log and documents increase in physical activity
- Patient is compliant with diet and/or exercise

Behavior and Lifestyle Modifications Discussed:

- Eat 3 meals daily with 1-2 high healthy snacks
- Eliminate caloric beverages
- Do not graze between meals
- Reduce consumption of packaged/processed foods
- Portion control
- Recipe modifications/cooking methods
- Choose low fat/low sugar items
- Perform 30 minutes of cardiovascular exercise per day, most days of the week
- Reducing stress and emotional eating
- Incorporating fruits and vegetables
- Take 15-20 minutes to eat meals

Goals for this month:

1. _____
2. _____
3. _____

Date of next appointment: _____

Patient to continue on current diet plan and return in one month.

Physician Signature (Required)

Date

(____)_____
Phone

Printed Name

Address (Required)