Nutrition Works Client Health History

Name:	**Birth Date:**	**Age:**	**Today's Date:**

List your main health concerns in order of importance:	**Duration of problem:**
1.	
2.	
3.	

What are you hoping to get out of your visit(s) with the dietitian?

Circle or write in your past or present medical conditions and/or symptoms:

☐ Heart disease	☐ Vitamin deficiency	☐ Gastric reflux (GERD)
☐ High blood pressure	☐ Anemia	☐ Celiac disease
☐ Pre-diabetes	☐ Osteopenia	☐ Diverticular disease
☐ Diabetes	☐ Osteoporosis	☐ Constipation
☐ PCOS	☐ Kidney disease	☐ Diarrhea
☐ High triglycerides	☐ Kidney stones	☐ Lactose intolerance
☐ High cholesterol	☐ Cancer	☐ Irritable bowel syndrome (IBS)
☐ Hypothyroidism	☐ Eating disorder	☐ Ulcerative colitis
☐ Gallbladder disease	☐ Anxiety	☐ Crohn's disease
☐ Migraine headaches	☐ Depression	☐ Food allergies/sensitivities

Other:

Significant family history?

Weight history:

Height:	Current Weight:	Most Weight:
Lowest weight in past **5** years:	Lowest weight past in past **10** years:	
Recent weight loss or gain? ☐ Yes ☐ No	How much? Over what time period?	Was recent loss/gain intentional? ☐ Yes ☐ No
Your preferred weight:	Are you looking for assistance with weight management? ☐ Yes ☐ No	

If yes, what approach has worked well for you in the past?

Please list all prescription or over-the counter medications, supplements and herbal preparations:

Name:	Dose:	Start Date:		Name	Dose:	Start Date:

--OVER--

Exercise	
How often do you exercise? ☐ Never ☐ Rarely ☐ Occasionally ☐ Frequently ☐ Every Day	
What type of exercise do you do?	How many minutes/hours per week (total)?
How long have you followed your current exercise routine?	How long has it been since your last check-up with your physician?
Has your doctor advised you to exercise? ☐ Yes ☐ No	Have any of your doctors placed restrictions on the type or amount of physical activity you should do ☐ Yes ☐ No If yes, what are your restrictions?

Health and social habits:	
Occupation:	Who does the shopping and cooking at home?
How are your cooking skills? ☐ good ☐ fair ☐ poor	Do you bring lunch to work? ☐ Yes ☐ No ☐ Sometimes
Number of times per week you eat food from a restaurant, fast-food, cafeteria or take-out? Include snacks, breakfast, lunch, and dinner:	Where?
Do you smoke? ☐ Yes ☐ No ☐ Quit _____ years ago	Do you salt your food? ☐ Yes ☐ No
Do you drink coffee or tea? ☐ Yes ☐ No How much? How do you take it?	Do you drink alcoholic beverages? ☐ Yes ☐ No What and how much?
Do you drink soda? ☐ Yes ☐ No What kind and how much?	Do you have any concerns about disordered eating thoughts or behaviors? ☐ Yes ☐ No
How many times a day do you eat?	Do you eat during the night? ☐ Yes ☐ No
If you are seeking assistance with weight management, what factors do you feel have contributed to your weight?	What are potential barriers to your success with changing your diet or lifestyle?

--OVER--

- Record all foods and beverages consumed for four days and nights before your visit.
- Describe the type of food, brand, and how it was prepared.
- List the amount consumed using cup, ounces, inches, etc.
- Don't forget snacks and beverages, and extras such as cream, sugar, margarine or mayo.

Circle type of day: Workday Non-Workday Holiday Prep: Write in where the food was prepared; Home-prepared (H), Restaurant (R), Take-out (TO) or Convenience Food (C)			Circle type of day: Workday Non-Workday Holiday Prep: Write in where the food was prepared; Home-prepared (H), Restaurant (R), Take-out (TO) or Convenience Food (C)		
Time	Prep	Food Amount	Time	Prep	Food Amount

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--OVER--

Nutrition Works LLC

805 Stevens Avenue
Portland, Maine 04103
(207) 772-6279
Fax (207) 347-4281

Susan Quimby, R.D., L.D.
Judy Donnelly, R.D., L.D.
Kim Norbert, M.S., R.D., L.D.
Patsy Catsos, M.S., R.D., L.D.
www.nutritionworks.us

Patient Registration
Please fill out and bring to your first visit.

(Please Print)

PATIENT INFORMATION					
Patient's Last Name: First: Middle:					
Street address:			Parent's Name (Minors):		
P.O. Box:	City:		State:	ZIP Code:	
Home Phone:	Work Phone:	Cell Phone:	Birth date: / /		Sex: ❑ M ❑ F
Occupation:	Email Address:		Can we send personal health information to your email address? ❑ Yes ❑ No		
Primary Care Physician:	Name, address and phone # of practice:				
Specialist (if applicable):	Name, address and phone # of practice:				

BILLING AND INSURANCE INFORMATION		
Insurance Company Name:	ID or Policy Number:	Group/Code:
Subscriber's Name:	Subscriber's Employer:	Subscriber's Birth Date / /
Patient's relationship to subscriber:	Are nutrition services coved by your insurance?	How many visits?
Do you have any other insurance? ❑ Yes ❑ No		

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www.nutritionworks.us

Privacy, Email, and Telehealth Consent

Nutrition Works, LLC needs your consent to use and disclose your protected health information to carry out treatment, payment and coordination of care with your other health care providers and to communicate with you. If you would like a more detailed description of such uses and disclosures please refer to our Notice of Privacy Practices, which you have the right to review before signing this consent. This consent is voluntary. You have the right to revoke this consent in writing, and the revocation will be effective except to the extent Nutrition Works, LLC has already acted in reliance on your consent. Please initial each permission in addition to signing at the bottom of the page.

- I consent to use of my protected health care information to coordinate care with my other health care providers. I give Nutrition Works LLC permission to request medical records from my health care providers for coordination of care and to send a summary note of my consultation to my physicians. _____ (initials)

- I give Nutrition Works, LLC permission to leave messages including personal health information such as the dates and times of appointments at any of my phone numbers. _____ (initials)

- I give Nutrition Works, LLC permission to include Protected Health Information at the email address I provided. I have been informed that the information sent by email is not encrypted. This means a third party may be able to access the information and read it, since it is transmitted over the internet. In addition, once the email is received by me, someone may be able to access my email account and read it. _____ (initials)

- I consent to receive nutrition services at Nutrition Works LLC via a secure telehealth (video-chat) platform, when an office visit is not available. Nutrition Works LLC will provide a link to the videochat at the email address I provided. I know I can stop using telehealth at any time and ask to receive service(s) in a face-to-face setting. However, if I choose face-to-face services, my appointment time and dietitian may change. _____ (initials)

Assignment of Benefits

Nutrition Works, LLC is a participating provider for many insurance plans. However, insurance policies vary greatly in their coverage of medical nutrition therapy and telehealth; our participation is NOT a guarantee of coverage.

- I understand it is *my* responsibility to know what benefits my employer/group has selected for coverage and to contact my insurance company with coverage questions prior to my visit. I understand that Nutrition Works, LLC may require a referral from my physician or pre-authorization from my insurance company. However, I understand a referral from my physician does not mean nutrition counseling or telehealth are covered benefits on my insurance policy.

- I authorize Nutrition Works, LLC to apply for benefits on my behalf for services rendered. I certify that the insurance information I have provided is correct and I authorize the release of all information, including medical information, for this or related claims.

- I understand that Nutrition Works, LLC will bill me for services rendered if my insurance company denies or rejects payment of my claim. I understand I am financially responsible for any remaining balance, such as co-payments, deductibles, cancellation or no-show fees. I understand if my account is 90 days past due, it will be sent to a collection agency; a $25 collection fee will be issued.

- I understand there is a $25 fee for returned checks.

Signed_____ Date: _____

Type your legal name here to sign this form