Nutrition Works Client Health History

Demographics and coordination of care:		
Your name:	Date of birth:	Today's date:
Primary care provider name:	Gastroenterology specialist name:	Other specialist name:

Circle or write in your medical conditions, significant history and nutrition concerns:

- ☐ Gastric reflux (GERD)
- ☐ Celiac disease
- ☐ Diverticular disease
- ☐ Constipation
- ☐ Diarrhea
- ☐ Gallbladder disease
- ☐ Ulcerative Colitis
- ☐ Crohn's disease
- ☐ Fatty liver disease
- ☐ Ileostomy
- ☐ Irritable bowel syndrome (IBS)
- ☐ Lactose intolerance
- ☐ Food sensitivity or intolerance
- ☐ Food allergy
- ☐ Small intestinal bacterial overgrowth
- ☐ Other:
- ☐ Vitamin deficiency
- ☐ Anemia
- ☐ Unintentional weight loss
- ☐ Underweight
- ☐ Overweight or obesity
- ☐ Osteopenia
- ☐ Osteoporosis
- ☐ Eating disorder
- ☐ Anxiety
- ☐ Depression
- ☐ Insomnia
- ☐ Kidney stones
- ☐ Endometriosis
- ☐ Heart disease
- ☐ High blood pressure
- ☐ Atrial fibrillation
- ☐ Stroke
- ☐ Pre-diabetes
- ☐ Diabetes
- ☐ PCOS
- ☐ Hypothyroidism
- ☐ High triglycerides
- ☐ High cholesterol
- ☐ Kidney disease
- ☐ Cancer
- ☐ Migraine headaches

Which of the above concerns is the **main reason** for your visit? If concerns related to overweight or obesity are your top priority, and you would like to reschedule with one of our weight management experts, please phone our office at 207-772-6279. Thank you.

List gastrointestinal or abdominal surgeries, including date:

Significant family history:

Weight history; please circle yes or no as needed:		
Height:	Current weight:	
Have you gained weight lately? ☐ Yes ☐ No Have you lost weight lately? ☐ Yes ☐ No	How much? Over what time period?	Was recent loss/gain intentional? ☐ Yes ☐ No
Your preferred weight:	Are you looking for assistance with working toward a healthy body weight? Yes No	Any concerns about disordered eating behaviors or thoughts? ☐ Yes ☐ No

--OVER--

Exercise, health, and eating habits:	
Has your doctor placed any limitations on your ability to exercise?	How many times per week do you exercise? Total hours per week?
What exercises or activities do you perform?	How many hours a night do you sleep?
How do you cope with stress?	Occupation and usual work hours?
Who plans the meals at home?	Who does the shopping? How often? Where?
Who does the cooking at home?	How much water do you drink?
What type of diet has your doctor recommended?	Do you smoke? ☐ Yes ☐ No Former smoker How many years ago did you quit?
Number of times per week eating takeout, restaurant, cafeteria or heat-and-serve food? Where/where from?	Do you follow a particular diet or food lifestyle? For how long? Has it helped with your gastrointestinal problems?

Please list all **prescription or over-the counter medications, dietary supplements and herbal preparation**s that you are currently taking. You can attach a separate list if you have one from medical records, as long as it is up-to-date.

Name, brand and strength, if applicable	**Prescribing/dosing details**	**Date started**	**Prescriber**
Examples: Multivitamin, Vitafusion	1 gummy daily	2005	self
Calcium carbonate, Nature Made 300mg	1 tablet, twice daily	8/2017	Dr. XYZ

--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

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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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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