

Date _____ Patient's Name _____

History _____

1. How many meals do you eat per day? _____ Snacks? _____

2. How often do you eat out? _____ How often do you drink alcohol? _____

3. Who shops for food? _____ Prepares meals? _____ For how many people? _____

4. Have you dieted? no yes – what worked, what did not work? _____

5. List any cultural or religious or other diet practices _____

6. List any physical activities that you do routinely _____

7. List any nutrient supplements you take _____

8. Check all obstacles to eating well: get too hungry angry lonely lazy bored tired
 saboteur social situations stress eating busy cravings cooking for 1
 other _____

9. On a scale of 1 – 10, how ready are you to make changes? 1=not at all 10=I'll do anything you say _____

10. Food intolerances or allergies? _____

11. If you did not bring your food journal, record some typical meals on the reverse \Rightarrow

12. List medications: _____

13. List other information that you feel may be helpful - what would you like to get out of this meeting?

Physical _____

Discussed _____

Policy Regarding Patient: I authorize my insurance company to pay the amount due on my pending claim for medical nutrition therapy to Nancy Dell. I agree I will make payment within 90 days of service if my insurance company has not paid and that it is my responsibility to contact my insurance company for reimbursement. **I AM RESPONSIBLE FOR FINDING OUT THE NUMBER OF VISITS MY INSURANCE WILL COVER.** I am responsible for visits beyond my covered visits. **COPAYS OR PAYMENTS FOR VISITS FOR WHICH I PAY ARE DUE AT TIME OF SERVICE.** I am subject to a \$10 fee if I need to be billed for my copay. I understand that my insurance does not cover my appointment time if I “no show” and I understand that I will be charged for that time. I am subject to a \$35 fee for “No Show” appointments or if I do not provide notice of cancellation at least 24 hours in advance. Bad checks are subject to a \$20 fee. I have received the Notice of Privacy Policy and had the opportunity to review it.

Signature of responsible party

Date