CLIENT INFORMATION:

NAME:_____ BIRTHDATE:___/___/_____ AGE:_____ SEX: ___

ADDRESS:_____ CITY:_____ STATE:____ ZIP:_____

MARITAL STATUS:_____

HEIGHT:_____

CURRENT BODY WEIGHT:_____ WEIGHT 6 MONTHS AGO: _____

SMOKE: YES OR NO

PHONE: (W)_____ (H)_____

SS #:_____ DRIVERS LICENSE #:_____

EMPLOYER:_____ OCCUPATION:_____ PHONE:_____

ADDRESS:_____ CITY:_____ STATE:_____ ZIP:_____

RESPONSIBLE PARTY:

SPOUSE OR PARENT NAME:_____

ADDRESS:_____ CITY: _____ STATE:_____ ZIP:_____

PHONE: (W)_____ (H)_____

SS #:_____ DRIVERS LICENSE #:_____

EMPLOYER:_____ OCCUPATION:_____ PHONE:_____

PATIENT REFERRED BY:_____

CURRENT MEDICATION:_____

ALLERGIES: _____

PLEASE CHECK IF YOU HAVE HAD ANY OF THE FOLLOWING MEDICAL CONDITIONS, OR IF A FAMILY MEMBER HAS:

YES	*NO*	
☐	☐	HEART DISEASE: INCLUDING HIGH CHOLESTEROL, HEART ATTACK, STROKE.
☐	☐	DIABETES
☐	☐	HEPATITIS OR OTHER LIVER COMPLICATIONS: INCLUDE JAUNDICE, CIRRHOSIS, FATTY LIVER
☐	☐	ANEMIA
☐	☐	KIDNEY DISORDERS
☐	☐	HIGH/LOW BLOOD PRESSURE
☐	☐	CURRENTLY PREGNANT OR LACTATING
☐	☐	OTHER:_____

_____

REASON FOR VISIT:

- ☐ DOCTOR REFERRAL
- ☐ WEIGHT LOSS
- ☐ WEIGHT GAIN
- ☐ WEIGHT MANAGEMENT
- ☐ OTHER

PLEASE CHECK ANY THAT MAY APPLY:

HAVE YOU BEEN EXPERIENCING:

- ☐ VOMITING
- ☐ DIARRHEA
- ☐ NAUSEA
- ☐ EXCESSIVE URINATION
- ☐ DECREASE IN URINATION
- ☐ EXCESSIVE THIRST
- ☐ INCREASE IN APPETITE
- ☐ DECREASE IN APPETITE
- ☐ WEIGHT LOSS
- ☐ WEIGHT GAIN
- ☐ HIGH BLOOD SUGAR
- ☐ LOW BLOOD SUGAR

DO YOU TAKE SUPPLEMENTS?_____

ARE YOU A VEGETARIAN?_____

INSURANCE INFORMATION:

PRIMARY INSURANCE:_____ ADDRESS:_____

INSURED NAME:_____ SS#:_____

BIRTHDATE:___/____/____

CERT #:_____ GROUP #:_____

SECONDARY INSURANCE:_____ ADDRESS:_____

INSURED NAME:_____ SS#:_____

CERT. #:_____ GROUP #:_____

I UNDERSTAND THAT ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE CLIENT, AND THAT THE CLIENT IS RESPONSIBLE FOR ALL THE CHARGES AT TIME OF SERVICES, REGARDLESS OF INSURANCE COMPANY:

_____ **DATE:_____**

SIGNATURE

NUTRITION COUNSELING CONTRACT

To My Clients:

A clear understanding of our financial agreement is essential for a comfortable therapeutic relationship. This agreement has been prepared with that goal in mind. Please study this document carefully, and feel free to ask any questions regarding any part, before initialing and signing.

☐ **Prepayment is required for appointment confirmation.**

☐ **A Twenty-four (24) hour notice is required for cancellations without fee.**

☐ **If you cancel less than 24 hours before your appointment, the full fee will be due unless we make other arrangements in advance.**

☐ **I will provide you with information necessary for filing insurance claims, and will assist you as much as possible. However, you are responsible for payment in advance, filing of claims, and other communications with your insurance company.**

ADDITIONAL AGREEMENTS:

Name:_____ ☐ Visa ☐ MC ☐ AE

Card #:_____ Exp. Date: _____

Billing Zip:_____

CCV Code:_____

_____ _____

Client Signature Date

_____ _____

Dietitian Signature Date