Lisa Stollman, MA, RDN, CDE, CDN
Nutrition History Form

Name: _____ Date: _____

Address: _____ Town/Zip code: _____

Phone (H) _____ (W) _____ (C) _____

Email: _____ Social security: _____

Occupation: _____ Date of birth: _____

Referral source: _____

Physician: _____

Address: _____ Phone: _____

Insurance: _____

Policy # _____ Group # _____ Is there another

plan? _____ If YES, please state which one: _____

Who is responsible for bill/copay? _____ Amount of copay: _____

Do you need a referral for this visit? YES NO
Do you have the referral with you? YES NO
Are you covered for nutrition visits? YES NO
Did you confirm coverage with your insurance provider? YES NO
Have you met your yearly deductible for Specialists? YES NO

You will be responsible for paying for today's visit if you did not confirm with your insurance provider.

Major nutrition concern(s):

_____

Height: _____ Weight: _____ Usual weight: _____
Weight at HS graduation: _____ Lowest/highest in last 5 years: ___/____

Medications_____
_____
_____

Supplements:_____
_____

Do you have a history of intestinal problems such as bloating, excessive gas, constipation or diarrhea:
_____

Do you take laxatives: _____

Food allergies/intolerances:_____

Do you smoke cigarettes? ___If yes, how many years?____# per day: ___

Medical history (illnesses, surgeries): _____

_____

Family medical history: _____

_____

Past diet history: _____

Exercise (how often/type/duration): _____

Eating Habits

Do you have times during which you eat uncontrollably? Please circle No Yes. If Yes, please explain: _____

Have you ever been diagnosed with an eating disorder? No Yes

Do you skip meals? No Yes If Yes, why? _____

Do you know how to cook? No Yes

Who does the cooking at home? _____

Who does the grocery shopping?_____

Eating Behaviors

	No	Yes		No	Yes
Do you eat standing up?			Do you eat fast?		
Do you eat in the car?			Do you eat when bored?		
Do you eat while watching TV?			Do you eat when stressed?		
Do you eat while reading or on the computer?			Do you eat when you are anxious?		
Do your prefer eating alone?			Do you eat when you are lonely?		
Do you eat with others?			Do you eat when you are not hungry?		
Do you read Nutrition Facts labels?			If yes, what do you look at on the label?		
What are your favorite foods?					
What foods do you avoid and why?					

Office Policy

I look forward to helping you achieve your health and nutrition goals. Making positive changes in your lifestyle is the cornerstone to good health. Here are my office policies which will help familiarize you with my practice.

Consultations

The initial visit is 45 to 60 minutes. Follow-up visits are 30 to 60 minutes. Office visits must end on time, so please be on time.

Please bring a three-day food record with you to the visit. If you have any recent lab work, bring that with you as well.

Referrals

If you need a referral from your physician, please bring it with you to the initial visit.

Cancellations

If you need to cancel your visit, please do so at least 48 hours prior to the visit. Otherwise you will be charged for the visit in full.

Insurance Payments

Please contact your insurance provider before we meet to ensure that you are covered for nutrition visits. If you *have not* met your yearly deductible for specialists, you should pay for the visit at the time of service and the claim will be sent to your insurance provider. If any fees are not covered by insurance, I understand that I am financially responsible for all accumulated charges. If I don't have a referral for this visit and require a referral, I will be responsible for paying for this visit today. All unpaid balances over 30 days will be sent to collection, which will increase fees by 35%. I will also be fully responsible for payment of any appointments not cancelled.

I have read above financial obligation clause.

_____	_____	_____
Responsible party	Relationship	Date

NOTICE OF PRIVACY PRACTICES PATIENT ACKNOWLEDGEMENT

PATIENT: DATE OF BIRTH:

I understand that under the Health Insurance Portability Accountability Act of 1998, I have certain rights to privacy in regards to my protected health information (PHI). I have received, read and understand the Notice of Privacy Practice.

The practice reserves the right to change their terms of its Notice of Privacy Practice. I understand the practice will provide current Notice of Privacy Practice on request.

Signature:

_____

Relationship to patient: ____Self _____Parent _____Guardian

Date: _____

Permission to Release Health Information

I grant the right to Lisa Stollman, RDN to release and/or obtain health information about _____ (patient's name) to my third party payers and the following healthcare providers or persons:

_____

_____.

Signature of Person completing this form:

_____

Relationship to patient: _____

Print Name: _____

Date: _____

9/2016