Lisa Stollman, MA, RDN, CDE, CDN, CLT
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 $150.00 for the visit.

*Credit Card Information*

To ensure that we are paid for visits not cancelled within 48 hours, unforeseen copays or denied insurance claims, we request to have a credit card on file. All missed visits will be charged $150.00. This information will not be shared with anyone.

Name on Credit Card: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Type of credit card: VISA Mastercard AmEx Debit HAS

Credit Card# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Exp. Date: \_\_\_\_\_\_\_ CVV\_\_\_\_\_\_\_\_\_

*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 donʼt 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 within 48 hours of scheduled visit.

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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to patient: \_\_\_\_\_\_\_\_\_Self \_\_\_\_\_\_\_\_\_\_Parent \_\_\_\_\_\_\_\_ Guardian

**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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4/2018