Medical Nutrition Therapy Intake Form

General Information:

Name: _____ Date: _____

Address: _____

Phone: _____ Email: _____

Age: _____ Date of Birth: _____ Gender: _____

Reason for Appointment: _____

_____

_____

_____

Primary Care Provider: _____

Address: _____

Therapist: _____

Address: _____

Employment Status: ☐Full Time ☐Part time ☐Not Employed

Place of Employment/Type of Work: _____

Education level: ☐Grammar school ☐High school ☐College ☐Graduate School

Grade in School: _____ Name of School: _____

Marital status: ☐Single ☐Married ☐Divorced ☐Separated ☐Widow

Significant Relationship: ☐Boyfriend ☐Girlfriend

Parent's marital status: ☐Single ☐Married ☐Divorced ☐Separated ☐Widow

Parent's occupation(s): _____

Siblings: ____Brother(s) ____Sister(s)

Number of Children: _____

Medical History:

Height: _____ Growth History: _____

Current Wt: _____ Wt 1 year ago: _____ Usual Wt: _____

Lowest Wt: _____ Highest Wt: _____ Desired Wt: _____

Have you recently lost/gained wt? ☐Yes ☐No Amount: _____

Was this an intentional change? ☐Yes ☐No

Do you weigh yourself? ☐Yes ☐No How often? _____

Are you concerned with your weight? ☐Yes ☐No

Birth weight: _____ Breast fed? _____ How long? _____

Mother's Height: _____ Father's Height: _____

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Do you drink alcohol? ☐Yes ☐No Number of drinks/wk:_____

Do you smoke cigarettes? ☐Yes ☐No Amount/day:_____

How long have you smoked?_____ If you quit smoking, when?_____

Do you use drugs? ☐Yes ☐No Explain:_____

Menstrual History:

Are you currently menstruating: ☐Yes ☐No ☐Have never menstruated

Age began menstruating: _____years of age

Date of last menstrual cycle:_____ Weight at that time:_____ pounds

Are you taking birth control pills/estrogen pills? ☐Yes ☐No

Do you experience PMS? ☐Yes ☐No

Symptoms:_____

Dieting History

How many times have you tried to lose weight? _____

Age of first attempt: _____ years Your weight at that time: _____pounds

What did you do?_____

Why did you go on the diet? _____

_____

Have you ever used any of the following for weight control?

Commercial diet programs	☐Yes	☐No	_____
Liquid diets	☐Yes	☐No	_____
Fad diets	☐Yes	☐No	_____
Prescription diet pills	☐Yes	☐No	_____
Over-the-counter diet pills	☐Yes	☐No	_____
Laxatives	☐Yes	☐No	_____
Diuretics	☐Yes	☐No	_____
Ipecac Syrup	☐Yes	☐No	_____
Vomiting	☐Yes	☐No	_____
Self Designed program	☐Yes	☐No	_____
Other	☐Yes	☐No	_____

Do you experience periods in which you eat uncontrollably? ☐Yes ☐No

If yes, how often?_____

At what age did this begin? _____years

Is this followed by:

☐Vomiting	Age began:_____	How often:_____
☐Laxative use	Age began:_____	How often: _____Amount: _____
☐Excessive exercising	Age began:_____	How often:_____
☐Self Harm	Age began:_____	How often:_____
☐Negative Emotions	Age began:_____	How often:_____

☐Other (explain)_____

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

Please Explain:_____

Are you currently or have you ever received treatment?_____

_____

_____

_____

Do you currently restrict food for weight control? ☐Yes ☐No

Please Explain:_____

Do you currently exercise for weight control? ☐Yes ☐No

Please Explain:_____

Exercise History:

Are you currently exercising: ☐Yes ☐No

List type, duration, frequency, and intensity of exercise activities:

_____

_____

_____

Have you exercised in the past year? ☐Yes ☐No

List type, duration, frequency, and intensity of exercise activities:

_____

_____

_____

Do you have any physical conditions that limit your ability/safety to exercise? ☐Yes ☐No

Please Specify:_____

Family Weight History:

Are any members of your family overweight? ☐Yes ☐No

Explain:_____

Are any members of your family underweight? ☐Yes ☐No

Explain:_____

Did/Does anyone in your family diet? ☐Yes ☐No

Explain:_____

Did/Does anyone in your family have an eating disorder? ☐Yes ☐No

Explain:_____

Does your family eat meals together? ☐Yes ☐No

What meals?_____

What is this like?_____

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Lifestyle:

Please list your current stresses:

What are your hobbies or interests?

Please describe what a typical day is like for you from when you wake until you go to bed (list activities, meals, & times):

How do weekends differ?

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Eating Habits:

Do you regularly skip meals? ☐Yes ☐No

How many days/wk do you eat Breakfast:_____ Lunch:_____ Dinner:_____ Snacks:_____

When do you usually snack? _____

Do you buy or pack your lunches: ☐Buy # days/week:_____ ☐Pack # days/week: _____

Do you eat out? ☐Yes ☐No

How often? _____

Do you order take out? ☐Yes ☐No

How often? _____

Do you eat fast food? ☐Yes ☐No

How often?_____

List restaurants you usually choose: _____

_____

Who does the grocery shopping? _____

Who prepares/cooks the meals? _____

Do you read food labels? ☐Yes ☐No

What do you look at on the label? _____

Do the nutrition facts influence your decision to eat the food?	☐Yes	☐No
Do you eat standing up?	☐Yes	☐No
Do you eat in the car?	☐Yes	☐No
Do you eat in front of the tv?	☐Yes	☐No
Do you eat while reading, on the computer, etc?	☐Yes	☐No
Do you eat with others?	☐Yes	☐No
Do you eat faster/slower than others?	☐Yes	☐No
Do you eat when you are stressed?	☐Yes	☐No
Do you eat when you are bored?	☐Yes	☐No
Do you eat when you are anxious?	☐Yes	☐No
Do you eat when you are lonely?	☐Yes	☐No
Do you eat when you are not hungry?	☐Yes	☐No
Do you know what hunger & fullness feel like?	☐Yes	☐No
Do you prepare your own meals?	☐Yes	☐No
Do you avoid certain foods?	☐Yes	☐No

Please Specify: _____

_____

What are your favorite foods? _____

_____

_____

What food don't you like? _____

_____

_____

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Disordered Eating Behaviors:

Please check if you experience any of the following:

- ☐ Count calories
- ☐ Count fat grams /sugar grams/ carbohydrate grams/ protein grams
- ☐ Avoid eating a food if you do not know how it was prepared
- ☐ Avoid eating a food if you do not know it's nutritional content
- ☐ Cut your food into small pieces
- ☐ Weigh/ measure your food
- ☐ Refuse to eat after certain hour
- ☐ Won't eat unless you are able to exercise or purge afterward
- ☐ Eat the same foods daily
- ☐ Are scared to try new foods
- ☐ Won't eat in front of others
- ☐ Hide food so others will think you ate it
- ☐ Hide food so you can binge
- ☐ Feel guilty after eating
- ☐ Eat foods that are different from the rest of your family
- ☐ Believe there are good foods and bad foods
- ☐ Feel ashamed of your eating
- ☐ Become upset if you are unable to eat at a certain time
- ☐ Become upset if you eat foods other that what you planned
- ☐ Feel food is controlling your life

Client's Impressions:

Do you feel that you have a problem with food and eating? ☐Yes ☐No

Is this something that you want to work on changing? ☐Yes ☐No

What are your goals? Please list and prioritize with #1 as most important.

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Food Intake Checklist:

Check what foods you consume. Briefly indicate frequency, amounts, and brands.

	Amount/Brand	Daily	Weekly	Monthly	Never
Example:					
Yogurt	*1 cup/Dannon Light*	*✓ (3 times a week)*			
Milk					
Cheese					
Yogurt					
Fruits					
Vegetables					
Red meat					
Poultry					
Fish					
Seafood					
Pork					
Eggs					
Nuts					
Cold cuts					
Soy foods					
Starchy beans					
Bread					
Pasta					
Rice					
Cereal					
Muffins					
Candy					
Cookies					
Desserts					
Fried foods (french fries, etc)					
Potato chips					
Soda, Snapple, Sobe					
Juice					
Butter, Margarine					
Salad dressing					
Other fats					
Other:					

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Malnutrition Signs/Symptoms:

Please check if you now, or have ever, experience any of the following:

- ☐ Irregular menstrual periods
- ☐ Absent menstrual periods
- ☐ Cold intolerance
- ☐ Tingling sensation in hands or feet
- ☐ Headaches
- ☐ Lightheadedness/ Dizziness
- ☐ Fainting
- ☐ Sleeping difficulties
- ☐ Skin changes
- ☐ Hair loss
- ☐ Hair growth on face and/or chest
- ☐ Chest pains
- ☐ Rapid heart beat
- ☐ Shortness of breath
- ☐ Mood Swings
- ☐ Episodes of crying for "no reason"
- ☐ Frequently thinking about food
- ☐ Confusion
- ☐ Difficulty concentrating
- ☐ Anxiety, especially around food
- ☐ Less social interaction with family
- ☐ Less social interaction with friends
- ☐ Frequently tired
- ☐ Memory problems
- ☐ Difficulty making decisions
- ☐ Problems with teeth
- ☐ Sore throat
- ☐ Swollen parotid glands
- ☐ Taste changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Muscle pain
- ☐ Joint pain
- ☐ Obsessive-compulsive behaviors
- ☐ Feelings of depression
- ☐ Other: _____

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Please indicate whether you or a family member have/had any of the following conditions:

Disease/Condition	Self	Family	Relationship	Treatment
Diabetes	☐	☐		
Kidney Disease	☐	☐		
Cardiovascular Disease	☐	☐		
Heart Attack	☐	☐		
Hypertension	☐	☐		
High Cholesterol	☐	☐		
Cancer	☐	☐		
Obesity	☐	☐		
Intestinal problems	☐	☐		
Menstrual problems	☐	☐		
Osteoporosis	☐	☐		
Food Allergies	☐	☐		
Food Intolerances	☐	☐		
Mental Health Issues	☐	☐		
Drug Dependency	☐	☐		
Asthma	☐	☐		
Headaches	☐	☐		
Other	☐	☐		

Are you currently being treated for any medical conditions: ☐Yes ☐No

Please Specify: _____

List any medications you are currently taking or have taken in the last year: _____

_____

_____

_____

Are you currently taking any food or nutritional/herbal supplements? ☐Yes ☐No

Please Specify: _____

_____

_____

_____

Has your doctor recommended you follow a special diet? ☐Yes ☐No

Please Specify: _____

Are you currently following this diet? ☐Yes ☐No

If not, please indicate why; If yes, indicate what changes you are making: _____

_____

_____

_____

_____

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NOTICE OF PRIVACY PRACTICES*

We Care About Your Privacy

1. Our Pledge Regarding Medical Information

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our organization. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

2. Our Legal Duty

Law Requires Us to:

1. Keep your medical information private.
2. Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
3. Follow the terms of the current notice.

We Have the Right to:

1. Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
2. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

Notice of Change to Privacy Practices:

1. Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

3. Use and Disclosure of Your Medical Information

The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us.

For Treatment:
We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other people who are taking care of you. We may also share medical information about you to your other health care providers to assist them in treating you.

For Payment:
We may use and disclose your medical information for payment purposes. A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include your medical information.

For Health Care Operations:
We may use and disclose your medical information for our health care operations. This might include measuring and improving quality, evaluating the performance of employees conducting training programs, and getting the accreditation, certificates, licenses and credentials we need to serve you.

Additional Uses and Disclosures:
In addition to using and disclosing your medical information for treatment, payment, and health care operations, we may use and disclose medical information for the following purposes.

Facility Directory:
Unless you notify us that you object, the following medical information about you will be placed in our facility directories: your name; your location in our facility; your condition described in general terms; your religious affiliation, if any. We may disclose this information to members of the clergy or, except for your religious affiliation, to others who contact us and ask for information about you by name.

Notification:
We may use and disclose medical information to notify or help notify: a family member, your personal representative or another person responsible for your care. We will share information about your location, general condition, or death. If you are present, we will get your permission if possible before we share, or give you the opportunity to refuse permission. In case of emergency, and if you are not able to give or refuse permission, we will share only the health information that is directly necessary for your health care, according to our professional judgment. We will also use our professional judgment to make decisions in your best interest about allowing someone to pick up medicine, medical supplies, x-ray or medical information for you.

Disaster Relief:
We may share medical information with a public or private organization or person who can legally assist in disaster relief efforts.

Fundraising:
We may provide medical information to one of our affiliated fundraising foundations to contact you for fundraising purposes. We will limit our use and sharing to information that describes you in general, not personal, terms and the dates of your health care. In any fundraising materials, we will provide you a description of how you may choose not to receive future fundraising communications.

Research in Limited Circumstances:
We may use medical information for research purposes in limited circumstances where the research has been approved by a review board that has reviewed the research proposal and established protocols to ensure the privacy of medical information.

Funeral Director, Coroner, Medical Examiner:
To help them carry out their duties, we may share the med-

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ical information of a person who has died (e.g., a coroner, medical examiner, funeral director, or an organ procurement organization.

Specialized Government Functions:
Subject to certain requirements, we may disclose or use health information for military personnel and veterans, for national security and intelligence activities, for protective services for the President and others, for medical suitability determinations for the Department of State, for correctional institutions and other law enforcement custodial situations, and for government programs providing public benefits.

Court Orders and Judicial and Administrative Proceedings:
We may disclose medical information in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant, or grand jury subpoena, we may share your medical information with law enforcement officials. We may share limited information with a law enforcement official concerning the medical information of a suspect, fugitive, material witness, crime victim or missing person. We may share the medical information of an inmate or other person in lawful custody with a law enforcement official or correctional institution under certain circumstances.

Public Health Activities:
As required by law, we may disclose your medical information to public health or legal authorities charged with preventing or controlling disease, injury or disability, including child abuse or neglect. We may also disclose your medical information to persons subject to jurisdiction of the Food and Drug Administration for purposes of reporting adverse events associated with product defects or problems, to enable product recalls, repairs or replacements, to track products, or to conduct activities required by the Food and Drug Administration. We may also, when we are authorized by law to do so, notify a person who may have been exposed to a communicable disease or otherwise be at risk of contracting or spreading a disease or condition.

Victims of Abuse, Neglect, or Domestic Violence:
We may use and disclose medical information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may share your medical information if it is necessary to prevent a serious threat to your health or safety or the health or safety of others. We may share medical information when necessary to help law enforcement officials capture a person who has admitted to being part of a crime or has escaped from legal custody.

Workers Compensation:
We may disclose health information when authorized or necessary to comply with laws relating to workers compensation or other similar programs.

Health Oversight Activities:
We may disclose medical information to an agency providing health oversight for oversight activities authorized by law, including audits, civil, administrative, or criminal investigations or proceedings, inspections, licensure or disciplinary actions, or other authorized activities.

Law Enforcement:
Under certain circumstances, we may disclose health information to law enforcement officials. These circumstances include reporting required by certain laws (such as the reporting of certain types of wounds), pursuant to certain subpoenas or court orders, reporting limited information concerning identification and location at the request of a law enforcement official, reports regarding suspected victims of crimes at the request of a law enforcement official, reporting death, crimes on our premises, and crimes in emergencies.

Appointment Reminders:
We may use and disclose medical information for purposes of sending you appointment postcards or otherwise reminding you of your appointments.

Alternative and Additional Medical Services:
We may use and disclose medical information to furnish you with information about health-related benefits and services that may be of interest to you, and to describe or recommend treatment alternatives.

4. Your Individual Rights

You Have the Right to:

1. Look at or get copies of certain parts of your medical information. You may request that we provide copies in a format other than photo copies. We will use the format you request unless it is not practical for us to do so. You must make your request in writing. You may ask the receptionist for the form needed to request access. There may be charges for copying and for postage if you want the copies mailed to you. Ask the receptionist about our fee structure.
2. Receive a list of all the times we or our business associates shared your medical information for purposes other than treatment, payment, and health care operations and other specified exceptions.
3. Request that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in the case of an emergency).
4. Request that we communicate with you about your medical information by different means or to different locations. Your request that we communicate your medical information to you by different means or at different locations must be made in writing to our Privacy Officer.
5. Request that we change certain parts of your medical information. We may deny your request if we did not create the information you want changed or for certain other reasons. If we deny your request, we will provide you with a written explanation. You may respond with a statement of disagreement that will be added to the information you wanted changed. If we accept your request to change the information, we will make reasonable efforts to tell others, including people you name, of the change and to include the changes in any future sharing of that information.
6. If you wish to receive a paper copy of this privacy notice, then you have the right to obtain a paper copy by making a request in writing to our Privacy Officer.

Questions and Complaints

If you have any questions about this notice, please ask the receptionist to speak to our Privacy Officer.

If you think that we may have violated your privacy rights, you may speak to our Privacy Officer and submit a written complaint. To take either action, please inform the receptionist that you wish to contact the Privacy Officer or request a complaint form. You may submit a written complaint to the U.S. Department of Health and Human Services; we will provide you with the address to file your complaint. We will not retaliate in any way if you choose to file a complaint.

*These privacy practices are currently in effect and will remain in effect until further notice.

PATIENT HIPPA ACKNOWLEDGEMENT

This office has made me aware of HIPPA Notice of Privacy Practices and I acknowledge receiving a copy of this notice for my review. A copy of this notice is also available at Columbus Laser Allergy for my future review. By signing this acknowledgment form I am in agreement to its terms.

_____ _____

Patient Signature Date

FOR PRACTICE USE ONLY

Practice Documentation of Good Faith Effort to Obtain Acknowledgement

Patient's acknowledgement of this Notice could not be obtained because:

□ Patient refused to sign
□ Communication barrier prohibited obtaining acknowledgement
□ Emergency circumstance
□ Other

Details: _____
_____

_____ _____

Practice Signature Date

Columbus Laser Allergy has a cancellation/no-show policy. Individuals are responsible for notifying the office of any cancellations **at least 24 hours** prior to their scheduled appointment. The individual is responsible for a $20 fee for any no-show or last minute cancellations that occur within 24 hours of their scheduled appointment. We withhold the right to rescind the cancellation/no-show policy on a case by case basis (as in instances of emergencies or acts of nature). Thank you for your cooperation.

_____ Initial