

PAGE 1: INITIAL HISTORY AND NUTRITION ASSESSMENT

<u>To be filled out by client</u>		<u>Reserved for Dietitian</u>																				
Name: _____ Date: _____ Address: _____ City: _____ State: _____ Zip: _____ Age: _____ Sex: _____ Home Phone: _____ Work Phone: _____ Date of Birth: _____ Email: _____		Referral Source: _____																				
Insurance Co: _____ Policy Number: _____ Subscriber's Name: _____ Subscriber's SSN: _____ Ins. I.D. Number: _____ Employer or Subscriber: _____		Additional Insurance Information: _____																				
Primary Physician: _____ Date of Last Check-up: _____ Reason for Seeing Dietitian: _____ How long had this condition/disease? _____ List any symptoms associated with this condition: _____ How has your life been effected by your medical condition? _____		Diagnosis/Chief Complaint: _____																				
<u>Personal Medical History:</u> <u>Place a check mark in front of the conditions you have or have had</u>		Medical History: _____																				
<table style="width:100%; border: none;"> <tr> <td><input type="checkbox"/> Heart Disease</td> <td><input type="checkbox"/> Diabetes</td> <td><input type="checkbox"/> Ulcer</td> </tr> <tr> <td><input type="checkbox"/> High Blood Pressure</td> <td><input type="checkbox"/> Obesity</td> <td><input type="checkbox"/> Gallbladder Disorder</td> </tr> <tr> <td><input type="checkbox"/> Hyperlipidemia</td> <td><input type="checkbox"/> Arthritis</td> <td><input type="checkbox"/> Constipation</td> </tr> <tr> <td><input type="checkbox"/> Cancer</td> <td><input type="checkbox"/> Anemia</td> <td><input type="checkbox"/> Diarrhea</td> </tr> <tr> <td><input type="checkbox"/> Lung Problems</td> <td><input type="checkbox"/> Chewing Problems</td> <td><input type="checkbox"/> Gastrointestinal Problems</td> </tr> <tr> <td><input type="checkbox"/> Food Allergies</td> <td><input type="checkbox"/> Food Sensitivities</td> <td><input type="checkbox"/> Other Allergies</td> </tr> <tr> <td><input type="checkbox"/> Other Medical Conditions _____</td> <td></td> <td></td> </tr> </table>				<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Ulcer	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Obesity	<input type="checkbox"/> Gallbladder Disorder	<input type="checkbox"/> Hyperlipidemia	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Constipation	<input type="checkbox"/> Cancer	<input type="checkbox"/> Anemia	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Lung Problems	<input type="checkbox"/> Chewing Problems	<input type="checkbox"/> Gastrointestinal Problems	<input type="checkbox"/> Food Allergies	<input type="checkbox"/> Food Sensitivities	<input type="checkbox"/> Other Allergies	<input type="checkbox"/> Other Medical Conditions _____
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<u>Patient Behavior</u>		Quality of Life: _____																				
	0=N/A	1=Never	2=Rarely	3=Sometimes	4=Often	5=Occasionally																
Excessive evening consumption																						
Portion Size control appropriately																						
Meal Replacements Uses appropriately																						
Food Guide Pyramid Eats accordingly to																						
Sets realistic wt. reduction goal																						
Gets appropriate physical activity																						

PAGE 2: INITIAL HISTORY AND NUTRITION ASSESSMENT

<u>To be filled out by client</u>	<u>Reserved for Dietitian</u>														
<p>Name: Marital Status: ___ Single ___ Married ___ Divorced/Separated ___ Widowed List seeing, hearing, other impairment: _____ Last Grade Completed: _____ Occupation: _____ Number of persons in household: _____ <u>Names</u> _____ <u>Relationship</u> _____ <u>Age</u> _____</p>	<p>Family & Social History</p>														
<p>Anyone else in household on special foods or meal plan? If so, what type of foods or meal plan? Who cooks for you? _____ How often do you eat at home per week? Name 3 or more foods you regularly prepare at home? How often do you eat out each week? <u>Where you eat out</u> _____ <u>What you order to eat</u> _____ How many meals/snacks do you eat a day? _____ How often to you eat breakfast a week? _____</p>	<p>Meal Plans:</p> <p>Servings Per Day:</p> <table border="1"> <tr><td>Dairy</td><td>_____</td></tr> <tr><td>Veg.</td><td>_____</td></tr> <tr><td>Fruit</td><td>_____</td></tr> <tr><td>Meat</td><td>_____</td></tr> <tr><td>Starch</td><td>_____</td></tr> <tr><td>Fat</td><td>_____</td></tr> <tr><td>Sweets</td><td>_____</td></tr> </table>	Dairy	_____	Veg.	_____	Fruit	_____	Meat	_____	Starch	_____	Fat	_____	Sweets	_____
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<p>List any foods you are allergic to: Food dislikes or foods you have problem eating (gas, stomach pain, etc.)</p>	<p>Problem Foods:</p>														
<p>Height: _____ Present Weight: _____ Usual Weight: _____ Goal Weight: _____ Pounds gained this year _____ Pounds lost this year _____ Are you on or have been on a special diet? _____ What type? _____ Where did you receive your information about the diet? _____ Did you stay on your meal plan? _____ How long? _____ Did you use the information you learned? _____ List the problems you had trying to follow your meal plan. What beverages do you drink each day? What types of diet foods are you using? Are you using any foods from a weight loss program? List any vitamin/mineral or health supplements you are taking.</p>	<p>Height:</p> <p>Weight:</p> <p>Barriers:</p> <p>Supplements:</p>														
<p>List all medications you are taking, time of day, and amounts (use back if needed)</p> <p>Alcohol Intake: _____ Drinks _____ Per Day _____ Per Week _____ Type: _____ Tobacco Intake: _____ None Smoker _____ Quit smoking recently _____ Pipe or Cigar _____ _____ Packs of Cigarettes a Day _____ Chewing Tobacco _____</p>	<p>Medications:</p> <p>Possible Drug/Nutrient Interactions:</p> <p>Substances:</p>														

PAGE 3: INITIAL HISTORY AND NUTRITION ASSESSMENT

<u>To be filled out by client</u>	<u>Reserved for Dietitian</u>
Name: _____	
Exercise Regularly? _____ If so, what types? _____ Minutes/Day _____ Days/week _____ Moderate _____ Total number of hours per week _____ or Vigorous _____ Willing to increase? _____ Injuries or limitations? _____ Other problems _____	Exercise: _____
Self Assessment of Stress Level: _____ High _____ Moderate _____ Low Personality Type: _____ impatient, time-oriented, competitive _____ Usually somewhat relaxed, sometimes anxious _____ Relaxed, easy going Any severe personal problems in the past 12 months? (such as death of family member, marital problems, divorce, job changed, accidents, law suits, serious family problems, ill health) _____ Relaxation Techniques Practiced? _____ Which ones? _____	Stress Assessment _____
Fasting Glucose g/dL _____ HgA1C _____ Can you monitor your Blood Glucose, if applicable? _____ If currently: Time of Day _____ Times per Week _____ Any Problems? _____ Can you monitor your Blood Pressure, if applicable? _____	Blood Glucose Monitoring: _____ Blood Pressure Monitoring: _____
What are you goals? _____ What help would you particularly like from the Dietitian? _____	Motivation: _____ Expectations: _____

This space is reserved for Medical Provider

Date:						
Blood pressure						
Total Cholesterol						
LDL						
HDL						
Triglyceride						
Waist Circumference						
Hip Circumference						
Waist-Hip Ratio						
BMI:						

B.A. Hughes & Associates, March 20, 2006

This information I give to the best of my knowledge:

Client's Signature: _____

Date: _____

B.A. Hughes & Associates

4208 Galax Drive, Raleigh, NC 27612

919-787-2949

NEW PATIENT INFORMATION

APPOINTMENT:

Individual appointments are scheduled for a specific time period. Most first time appointments are scheduled for 1.5 hours. Allow from 45 minutes to one hour for follow up visits. Each patient should count on at least 2 follow up visits. Please call 24 hours in advance for cancellations.

MEDICAL INSURANCE:

B.A. Hughes & Associates has been credentialed to provide medical nutrition therapy by CIGNA, AETNA, Duke Select/Duke Basic, WellPath–A Coventry Health Care Plan, and Blue Cross Blue Shield of North Carolina (Blue Advantage, Blue Care and Blue Options only). The NC State Health Plan (Medco) permits reimbursement to registered and licensed dietitians/nutritionists only for diabetes care and only if the member has a PPO plan. **(CALL YOUR STATE GENERAL ASSEMBLY MEMBERS TO REQUEST MEDICAL NUTRITION THERAPY AS A BENEFIT.)**

PAYMENT :

B.A. Hughes & Associates will file for reimbursement form your insurance company if it is one listed above. Co-payment or payment by clients without insurance is expected at time of appointment. Checks are to be made payable to B.A.Hughes & Associates. Credit cards are **NOT** accepted. If payment of \$200 for the first visit and \$85 for follow up visits is a concern, **PLEASE** negotiate with us at time of initial contact. **EXPECT TO BE BILLED \$30 FOR MISSED APPOINTMENTS UNLESS WE ARE NOTIFIED OF CANCELLATIONS AT LEAST 24 HOURS IN ADVANCE.**

I hereby acknowledge responsibility for this account and assume and guarantee payments of all charges against this account as they accrue.

Signature of responsible party/patient _____

Date _____

02/29/08