

PAGE 2: INITIAL HISTORY AND NUTRITION ASSESSMENT

<u>To be filled out by client</u>	<u>Reserved for Dietitian</u>														
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> _____	Family & Social History														
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 do you eat breakfast a week? _____	Meal Plans: Servings Per Day: <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	_____
Dairy	_____														
Veg.	_____														
Fruit	_____														
Meat	_____														
Starch	_____														
Fat	_____														
Sweets	_____														
List any foods you are allergic to: Food dislikes or foods you have problem eating (gas, stomach pain, etc.)	Problem Foods:														
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.	Height: Weight: Barriers: Supplements:														
List all medications you are taking, time of day, and amounts (use back if needed) 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	Medications: Possible Drug/Nutrient Interactions: Substances:														

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<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, August 18, 2010

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

Updated 8.27.10

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. BCBSNC plans provide 6 free visits. We phone your insurance to determine the number of visits you are permitted. Most plans permit number of visits based on "medical necessity." **PLEASE CALL OR E-MAIL US 24 HOURS IN ADVANCE FOR CANCELLATIONS.**

MEDICAL INSURANCE:

B.A. Hughes & Associates, LLC, has been credentialed to provide medical nutrition therapy by AETNA, CIGNA Healthcare, Blue Cross Blue Shield of North Carolina (Blue Advantage, Blue Care and Blue Options), Federal Blue Cross Blue Shield, and some other state Blue Cross Blue Shield plans.

THE NORTH CAROLINA STATE HEALTH PLAN (Medco) will reimburse for individuals with diabetes (6 visits free) and all other state employees or retirees 4 visits plus a \$25 copayment.

MEDICARE coverage applies for medical nutrition therapy for diabetes and non-end-stage renal diseases.

PAYMENT:

B.A. Hughes & Associates will file for reimbursement from 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 \$100 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_____