21 W 2nd Street, Suite 1
Riverhead, NY 11901
631-740-9330

Welcome to East End Nutrition,

We want to thank you for taking the time to complete the following forms. Completing these forms prior to your appointment will allow you to be as detailed as possible and will give us more time at your visit to focus on nutrition.

At East End Nutrition we view each patient as an individual, creating goals and treatment plans that work with your lifestyle. This approach offers an avenue to more a realistic and practical treatment with better success in finding long-term and sustainable wellness.

We value the concept of a patient-centered multidisciplinary approach to your healthcare. We will work as a team with your doctors and other healthcare providers to assist you to your best health. Education and accountability are important in each patient's care plan: We will give you the tools to live a healthier life.

We look forward to meeting with you. Please feel free to contact us by phone with any questions before and after your nutrition visit.

REMEMBER: If you "No Show" for your appointment or do not cancel 24 hours in advance, you will be charged a $50.00 "No Show" fee.

Healthfully yours,
East End Nutrition, PLLC

New Patient Form

Note: this is a "fillable" form you can choose to type-in your information by tabbing through the form before printing.
***TIP: click immediately after the question for the fill-in area**. If you are handwriting please do so clearly.*
Bring this form with you to your first appointment.

Patient Name: | Gender: ☐ M ☐ F

Date of Birth: | Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Divorced ☐ Widowed

Social Security Number:

Street Address:

City: | State: | Zip:

Phones/Home: | Work: | Cell:

Email: | We will add you to the Quarterly Nutrition Newsletter if that's OK ☐ No Thanks

How would you prefer to be contacted?: ☐ Email ☐ Cell ☐ Work ☐ Home

Occupation: ☐ Retired ☐ Out of work

Primary Care Physician: | Phone:

Referring Physician: | Phone:

If not referred by a physician, how did you hear about us?:

Insurance Information.

Not all insurance companies provide coverage for medical nutrition therapy or nutrition counseling. Please verify coverage with your provider. Note that patient is responsible for all non-covered charges including co-pays, co-insurance, deductible, or non-covered services.

Primary Insurance:

Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

What is your Nutrition copay? $ | Have you met your deductible? ☐ Yes ☐ No ☐ N/A

Subscriber ID # (OR ATTACH CARD)

Complete if Primary Insurance Holder is not patient:

Primary Insured Name: | Date of Birth:

Insured Social Security Number:

Address: | City: | State: | Zip:

Secondary Insurance:

Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Subscriber ID # (OR ATTACH CARD)

Complete if Primary Insurance Holder is not patient:

Primary Insured Name: | Date of Birth:

Insured Social Security Number:

Address: | City: | State: | Zip:

ANTHROPOMETRICS

Height:	Current Weight:	Desired Weight:
Highest Adult Weight:	When:	
Lowest Adult Weight:	When:	
Have you gained or lost weight in the last 6 months to a year?	☐ Yes ☐ No	
Please explain:		
Are you Pregnant? ☐ Yes ☐ No	Due Date:	

MEDICATIONS and SUPPLEMENTS: Please provide the names of any medications and/or supplements that you are currently taking. Include both prescription and over the counter medications and supplements. Please also list any meal-replacement products (i.e. SlimFast) and calorie/protein drinks (ie Ensure):

We can copy your medication list if you have one, and then don't worry about filling out this section.

Medication/Supplement	Dose	Reason you take this	Start Date
Example: Lipitor	***20 mg***	***High cholesterol***	***May 2011***
Example: One a Day vitamin – Women's 50+	***1 tablet***	***General health***	***Jan 2012***
Example: Biotin	***1000 mg***	***Hair and Nails***	***July 2014***

Reason for visit. What is the primary reason for your visit today?:

MEDICAL AND SURGICAL HISTORY

Please indicate whether you or your relatives* have been diagnosed with any of the following diseases or conditions. *Relatives include: parents, grandparents, and siblings.

Disease/Condition	Self	Relative	Disease/Condition	Self	Relative
ADHD	☐	☐	High Triglycerides	☐	☐
Allergies (non-food)	☐	☐	HIV/AIDS	☐	☐
Alzheimer's/Dementia	☐	☐	Hypertension (high blood pressure)	☐	☐
Amputation	☐	☐	Hyperthyroid	☐	☐
Anemia	☐	☐	Hypoglycemia (low blood sugar)	☐	☐
Asthma	☐	☐	Hypothyroid	☐	☐
Autoimmune condition	☐	☐	Hysterectomy	☐	☐
Anxiety	☐	☐	Intestinal Disease	☐	☐
Autism Spectrum Disorders	☐	☐	Irritable Bowel Syndrome (IBS)	☐	☐
Bariatric Surgery: Band	☐	☐	Kidney disease/failure	☐	☐
Bariatric Surgery: Bypass	☐	☐	Kidney stones	☐	☐
Bowel Resection	☐	☐	Lung disease	☐	☐
Bronchitis	☐	☐	Liver disease	☐	☐
Cancer	☐	☐	Metabolic Syndrome	☐	☐
Celiac Disease	☐	☐	Oral Pain	☐	☐
Chronic Fatigue Syndrome	☐	☐	Osteoarthritis	☐	☐
Cirrhosis	☐	☐	Osteoporosis	☐	☐
Constipation	☐	☐	Pancreatitis	☐	☐
COPD	☐	☐	Parkinson's Disease	☐	☐
Crohn's Disease	☐	☐	Peptic Ulcers	☐	☐
Depression	☐	☐	Phenylketonuria/PKU	☐	☐
Diabetes: Type 1	☐	☐	Polycystic Ovarian Syndrome	☐	☐
Diabetes: Type 2	☐	☐	Prostate Problems	☐	☐
Diabetes: Pre-Diabetes	☐	☐	Psychiatric Conditions	☐	☐
Diabetes: Gestational	☐	☐	Rheumatoid Arthritis	☐	☐
Diarrhea	☐	☐	Sickle Cell Disease	☐	☐
Diverticulosis/Diverticulitis	☐	☐	Sinusitis	☐	☐
Eating Disorder	☐	☐	Sleep apnea	☐	☐
Emphysema	☐	☐	Stroke	☐	☐
Epilepsy or seizures	☐	☐	Substance Abuse	☐	☐
Fibromyalgia	☐	☐	Swallowing/Chewing Difficulty	☐	☐
Food Allergies	☐	☐	Ulcerative Colitis	☐	☐
Food Sensitivities	☐	☐	Urinary Tract Infections	☐	☐
Gallbladder Disease/Gallstones	☐	☐	OTHER Disease/Condition (please specify):		
Gall Bladder Removal	☐	☐		☐	☐
Gout	☐	☐			
Heart attack/Angina	☐	☐		☐	☐
Heartburn	☐	☐			
Heart Disease	☐	☐		☐	☐
Heart Failure	☐	☐			
Hepatitis	☐	☐		☐	☐
High Cholesterol	☐	☐			

LIFESTYLE. Tell us a little bit about yourself.

Do you have children? ☐ Yes ☐ No Ages?:

Who do you live with?

Which meals do you eat regularly? ☐ Breakfast ☐ Lunch ☐ Dinner ☐ Snacks

Who prepares the majority of your meals?

Who shops for food?

Where do you shop for food?

If you do, how much time do you spend cooking/preparing meals each day? hrs/min

How often do you have take-out each week?	☐ Rarely	☐ 1-2 times	☐ 3-4 times	☐ 5-6 times	☐ 7+ times

From where does take-out come?

How often to you eat out each week?	☐ Rarely	☐ 1-2 times	☐ 3-4 times	☐ 5-6 times	☐ 7+ times

What restaurants?

Do you find cooking difficult? ☐ Yes ☐ No Describe:

How often do you exercise? ☐ None ☐ Light (1-2X/wk) ☐ Moderate (2-3X/wk) ☐ Active (>4X/wk)

Please describe exercise activity:

Does anything limit you from being physically active?

On average, how many hours of sleep do you get? Weekdays: Weekends:

Do you smoke? ☐ Never ☐ In the past ☐ Currently How long?

Do you drink alcohol? ☐ Never ☐ In the past ☐ Currently

Type/Amount/Frequency?

Drug use? ☐ Never ☐ In the past ☐ Currently

Type/Amount/Frequency?

Indicate daily stressors and rate the level of stress from 1 (extremely low) to 10 (extremely high):

Work:	Family:	Social:	Financial:	Health:	Other:

What helps you to unwind?

Eating Style. Based on how you eat on a regular basis, please check all that apply:

Inconsistent meal pattern/timing	☐	Snack late at night	☐
Skip meals	☐	Eat standing up	☐
Eat very fast	☐	Eat in the car	☐
Eat until you are uncomfortably full	☐	Eat while watching TV	☐
Binge or eat without being able to stop	☐	Eat while reading or on the computer	☐
Use food as a reward	☐	Eat with others	☐
Have specific cravings	☐	Eat when bored	☐
Eat when stressed	☐	Eat when you are hungry	☐
Eat when you are anxious	☐	Eat when you are not hungry	☐

Diet Rules

Do you follow any special diet or have diet restrictions or limitations for any reason (health, cultural, religious or other)? Please explain:

Have you ever been advised by your physician to follow a special diet? ☐ Yes ☐ No

What type? Are you currently following that diet? ☐ Yes ☐ No

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 avoid certain foods or food groups? ☐ Yes ☐ No

What do you avoid?

Please list any food allergies, sensitivities or intolerances:

Readiness. On a scale of 1 (not willing) to 5 (very willing), please indicate your readiness/willingness to do the following:

To improve your health, how ready/willing are you to...	1	2	3	4	5
Significantly modify your diet	☐	☐	☐	☐	☐
Take nutritional supplements each day	☐	☐	☐	☐	☐
Keep a record of everything you eat each day	☐	☐	☐	☐	☐
Modify your lifestyle (ex: work demands, sleep habits, physical activity)	☐	☐	☐	☐	☐
Practice relaxation techniques	☐	☐	☐	☐	☐
Engage in regular exercise/physical activity	☐	☐	☐	☐	☐

Consent for Nutrition Services & Acknowledgement Confirming Receipt Of Privacy Notice

I am employing the nutrition services of East End Nutrition, PLLC so that I may obtain information and guidance about health factors within my own control (diet, nutrition, and related behaviors) in order to support my health and wellness. I will be provided education to enhance my knowledge of health as it relates to foods, dietary supplements, and behaviors associated with eating. While nutritional and botanical support can be an important compliment to my medical care, I understand nutrition counseling is not a substitute for the diagnosis, treatment, or care of disease by a physician.

Co-pay charges and appointment fees are required to be paid at the time of each appointment. Visa, MasterCard, Cash, and Personal Checks are accepted. In the event that a check is returned for insufficient funds, I understand I will be charged a $35.00 fee.

I agree to be personally and fully responsible for payment of all non-covered charges related to any and all treatments provided by East End Nutrition, PLLC. I understand that East End Nutrition, PLLC may not be a participating practitioner with my insurance company/provider. In the case that East End Nutrition, PLLC does participate with my provider they will file these claims for me. I authorize the release of my medical information necessary to process the claim. East End Nutrition, PLLC will call my insurance to verify coverage, but I understand that this is a courtesy and not a guarantee of payment by my insurance company. If these charges are filed and denied, the remaining balance will be billed directly to me. I understand that I will be notified as to what coverage for services my insurance company allows including a reference number when available. Any overages (visits in excess of the policy limit) will be my responsibility. Any payment on this account will be considered an attempt to make this account current and will not be sent to collections. In the event that my account has to be turned over to collections or court, I give my permission for a $30.00 collection fee to be added to my account.

For my convenience, I will be provided a “Superbill” upon request to file for reimbursement with my insurance company or to use for tax purposes.

In the event that I fail to show up for my scheduled nutrition appointment and/or cancel my appointment within 24 hours of the appointment, I understand that I will be charged a “no show” fee of $50.00. As a courtesy to other patients, I understand that if I am late to my appointment, I will forfeit any time missed and if I am more than 15 minutes late to the appointment, I understand that I will be considered a "no show". (I understand that it my responsibility to have all intake paperwork completed prior to the scheduled appointment time.)

I understand that it is my responsibility to read all instructions on all supplements, read all ingredients in all supplements, and contact my healthcare provider in reference to any questions regarding medication or health concerns prior to taking any supplements. It is my responsibility to confirm any and all exercise and nutrition recommendations with my healthcare provider. I understand that any supplemental purchases are not refundable and not exchangeable due to the perishable nature of the products.

I give permission to East End Nutrition, PLLC. to leave a voice mail if needed with the phone numbers I listed. I also give East End Nutrition, PLLC. permission to contact me at the email address provided.

I have reviewed and understand East End Nutrition, PLLC.'s Notice for Privacy Practice. I understand that a copy is available in the waiting room and online for patients to review. I understand that I may request a copy of the Notice of Privacy Practice at any time.

X

Signature of Patient (or Parent/Guardian/Responsible Party) Date

Printed Name

Authorization to Obtain/Release Confidential Medical Information

Patient Name:	
Date of Birth:	Patient Phone Number:

I authorize East End Nutrition, PLLC to share/retrieve my treatment progress and health care information/medical records with medical professionals and the following individuals for the purpose of coordinating my care:

☐ PRIMARY CARE PHYSICIAN (PCP)

Name:	Phone Number:
Address:	

☐ REFFERING PHYSICIAN/NURSE PRACTIONIER (NP)/PHYSICIAN'S ASSISTANT (PA)

Name:	Phone Number:
Address:	

☐ SPECIALIST (i.e. Endocrinologist, Cardiologist, etc.):

Name:	Phone Number:
Address:	

☐ OTHER:

Name:	Phone Number:
Address:	

☐ I choose not to disclose my information for the purpose of coordinating my care.

I understand that my records and treatment are confidential and will not be disclosed without my written consent unless under legal compulsion. I also understand that I may revoke this consent at any time, except to the extent that action has been taken in reliance therein.

X

Signature of Patient (or Parent/Guardian/Responsible Party) ____________ Date

Printed Name