



NEW PATIENT FORM

Welcome,

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.

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

East End Nutrition, PLLC
New Patient Form

If you are handwriting please do so clearly. Bring this form with you to your first appointment.

Patient Name:		Gender: <input type="checkbox"/> M <input type="checkbox"/> F	
Date of Birth:	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Partnered <input type="checkbox"/> Divorced <input type="checkbox"/> 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 <input type="checkbox"/> No Thanks	
How would you prefer to be contacted?: <input type="checkbox"/> Email <input type="checkbox"/> Cell <input type="checkbox"/> Work <input type="checkbox"/> Home			
Occupation:		<input type="checkbox"/> Retired <input type="checkbox"/> 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: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	
What is your Nutrition copay? \$	Have you met your deductible? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Please explain:		
Are you Pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No	Due Date:	

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

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

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

East End Nutrition, PLLC 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
<i>Example: Lipitor</i>	<i>20 mg</i>	<i>High cholesterol</i>	<i>May 2011</i>
<i>Example: One a Day vitamin – Women's 50+</i>	<i>1 tablet</i>	<i>General health</i>	<i>Jan 2012</i>
<i>Example: Biotin</i>	<i>1000 mg</i>	<i>Hair and Nails</i>	<i>July 2014</i>

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

East End Nutrition, PLLC
Lifestyle, Eating, and Diet Rules

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:
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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	<input type="checkbox"/>	Snack late at night	<input type="checkbox"/>
Skip meals	<input type="checkbox"/>	Eat standing up	<input type="checkbox"/>
Eat very fast	<input type="checkbox"/>	Eat in the car	<input type="checkbox"/>
Eat until you are uncomfortably full	<input type="checkbox"/>	Eat while watching TV	<input type="checkbox"/>
Binge or eat without being able to stop	<input type="checkbox"/>	Eat while reading or on the computer	<input type="checkbox"/>
Use food as a reward	<input type="checkbox"/>	Eat with others	<input type="checkbox"/>
Have specific cravings	<input type="checkbox"/>	Eat when bored	<input type="checkbox"/>
Eat when stressed	<input type="checkbox"/>	Eat when you are hungry	<input type="checkbox"/>
Eat when you are anxious	<input type="checkbox"/>	Eat when you are not hungry	<input type="checkbox"/>

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:

East End Nutrition, PLLC
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.

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 10 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.) We do realize that on rare occasions emergencies or circumstances may arise beyond your control. We will address these situations with you should that occur.

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 and/or text to the cell number 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

East End Nutrition, PLLC Financial Agreement

Each insurance company and each plan within that company has different coverage parameters for Medical Nutrition Therapy. While we are contracted with many of these insurance plans they may cover less than you thought they might or you may have a deductible to meet first. You may have scheduled a visit that is not covered by your insurance; it is the patient's responsibility to check their benefits prior to being seen.

Please be familiar with the benefits provided by you're your health plan.

If your insurance requires a referral or if we need insurance authorization prior to your visit, it is YOUR responsibility to see that your health plan requirements are met. If your insurance information or other documents needed are not provided at or prior to your first visit, any charges incurred will be your responsibility.

Some questions you should ask your insurance provider:

Is a referral from my primary doctor required?

Is my diagnosis of _____ covered? (Some examples: diabetes, obesity, high blood pressure, IBS, etc.)

How many visits are covered over what period of time?

Do I have a co-pay or deductible?

Co-pays are due at time of service. We charge \$35.00 for any NSF checks. Should the account be referred over to our collection agency the undersigned, or their agent, will be responsible for payments of interest on the unpaid balance of 1% per month from the date of the service, collection fees, reasonable attorney fees and court costs.

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 the reason for my visit may not be a covered diagnosis by my insurance provider. 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.

With my signature, I acknowledge that I have read the above statement and agree to pay any charges within 30 days of receipt of statement. I authorize the dietitian to release my information required to process my insurance claims and authorize my insurance company to make payment directly to my dietitian.

I HAVE READ THE FINANCIAL AGREEMENT. I UNDERSTAND AND AGREE TO THIS POLICY.

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: _____

REFERRING PHYSICIAN/NURSE PRACTITIONER (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