NEW PATIENT FORM

Full Name:	
Date of birth:	

Demographic Information

Please enter your current details in the fields below:

Street Address:		
City, State, Zip		
Primary phone #	☐ **C** ☐ **H** ☐ **W**	
Secondary phone #	☐ **C** ☐ **H** ☐ **W**	
Email address:		
Preferred contact method/s: ☐ Primary phone ☐ Email ☐ Secondary Phone		
Can we leave a message?	☐ **Yes** ☐ **No**	
Emergency contact:		**Phone:**
Marital status:	☐ Single ☐ Married ☐ Partnered ☐ Divorced ☐ Widowed	
Occupation:		
How did you hear of us?		
Reason for visit:		
Members of household: (who do you live with)		

Food & Nutrient Intake

Food allergies:
Food intolerances and sensitivities:
Dietary restrictions / limitations:
Eating out frequency: Details:
Grocery shopping: Where?
Meal preparation and cooking: Who?

Insurance Information

Primary insurance name:			
Type of plan:		**Phone number:**	
Insured's name:		**DOB:**	
Relationship:			
Specialist co-pay: $			
Membership ID number:		**Group ID number**	
Secondary insurance name:			
Type of plan:		**Phone number:**	
Insured's name:		**DOB:**	
Relationship:			
Specialist co-pay: $			
Membership ID number:		**Group ID number:**	

Your Doctors

Primary physician name:		**Phone number:**	
City, State:			
Date of last physical:		**Date of last blood test:**	
Other important healthcare providers:			

Family History

Do you have a family history of the following? Please check all that apply.

☐ - Cancer	☐ - High blood cholesterol	☐ - Liver disease
☐ - Diabetes	☐ - High blood pressure	☐ - Thyroid disease
☐ - Heart disease	☐ - Kidney disease	☐ - Obesity

Other family medical history: _____

_____

Medical History

Please select if you have been diagnosed with or currently have, any of the following medical conditions:

☐ -Alcohol abuse	☐ -Falls	☐ -Liver disease Details:
☐ -Anemia	☐ -Fibromyalgia	☐ -Lung disease Details:
☐ -Anxiety or panic attacks	☐ -Gallbladder disease / gallstones	☐ -Metabolic syndrome
☐ Arthritis	☐ -Gout	☐ -Memory problems Details:
☐ Asthma	☐ -Hearing problems	☐ - Myocardial infarction / angina
☐ -Autoimmune condition	☐ -Headaches / migraines	☐ -Osteoporosis / osteopenia
☐ -Back pain	☐ -Hay fever	☐ -PMS
☐ -Bronchitis	☐ -Heartburn	☐ -Polycystic ovary syndrome
☐ -Cancer Type:	☐ -Heart disease Details:	☐ -Pneumonia
☐ -Depression	☐ -Haemorrhoids	☐ -Pre-diabetes
☐ -Diabetes Type:	☐ -Hepatitis	☐ -Prostate problems
☐ -Drug abuse	☐ -High cholesterol levels	☐ -Psychiatric conditions Details:
☐ -Diverticulitis	☐ -Hypertension (high blood pressure)	☐ -Sinusitis
☐ -Dry itchy skin, rashes, dermatitis	☐ -HIV/AIDS	☐ -Sleep apnea
☐ -Eating disorder Details:	☐ -IBD (Crohn's or ulcerative colitis)	☐ -Stomach ulcers
☐ -Eczema	☐ -Irritable bowel syndrome (IBS)	☐ -Stroke
☐ -Epilepsy, convulsions, seizures	☐ -Joint pain / joint replacement Details:	☐ -Thyroid disease / condition Details:
☐ -Erectile dysfunction	☐ -Kidney disease Details:	☐ -Urinary tract infection
☐ -Eye disease Details:	☐ -Kidney stones	☐ -Vitamin D deficiency
Other medical conditions:		
Past surgeries / hospitalizations:		

Females Only

If you are female, please answer the following questions.

Currently pregnant:	☐ Yes ☐ No	**Due date:**	
Previous pregnancies:	☐ Yes ☐ No	**Details:**	
Currently lactating:	☐ Yes ☐ No	**Duration:**	

Medication & Supplements

Please list all prescription and over-the-counter medications, vitamin, mineral and nutritional supplements, herbs/botanicals and diet aids you are currently taking.

Name of Medication / Supplement	Reason	Dose & Frequency

Lab Results

Please have your doctor fax your most recent lab work to us at 631-207-8414.

Weight History

Please enter your current weight and height as well as information about what your weight was like in the past.

Estimated weight:	
Height:	

Diet Rules

Do you follow any special diet or have diet restrictions or limitations for any reason (health, cultural, religious, or other)?	☐ Yes ☐ No
Please explain:	
Have you ever been advised by your physician to follow a special diet?	☐ Yes ☐ No
If yes, what type?	
Are you currently following that diet?	☐ Yes ☐ No

Physical Activity

Do you regularly participate in physical activity/exercise? | ☐ Yes ☐ No			
If the answer is yes, please described below. If you are unable to exercise, please provide details.			
Regular physical activity / exercise:	☐ Yes ☐ No	**Type:**	
Session duration:			
Frequency:			
Barriers to exercising:	☐ Yes ☐ No	**Details:**	

Social History

Social (Relationships/Support/Family):	
Amount of sleep on week nights:	
Amount of sleep on weekend nights:	
Frequency of alcohol intake/Type/Quantity:	
Other (drugs, etc.):	

Stress

On a scale from 1-10 with 10 being the highest, how would you rate your daily level of stress?

Stress rating (0 = no stress & 10 = extreme stress):	
Details:	

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					

Other Information

Is there any other information that you think we should know about?	
Are you interested in receiving our newsletter?	☐ Yes ☐ No
Are you interested in hearing more about a personalized meal plan?	☐ Yes ☐ No

Disclaimer

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.

Below you will find detailed information regarding your rights and responsibilities and established policies of this practice. Please read this carefully and and select the checkbox at the end of each section if you agree. Please feel free to ask any questions for clarification:

Agreement to Use Electronic Signatures and Electronic Documents

You agree that the electronic signatures included in this notice are intended to authenticate this writing and to have the same force and effect as manual signatures.

Electronic signature means any electronic sound, symbol or process attached to or logically associated with a record and executed and adopted by a party with the intent to sign such record, including (without limitation) typing a name or clicking a check box.

You agree to use electronic documents, notices and contacts "electronic documents", for all future transactions and communications. Electronic documents contain the same information as paper documents, notices and contracts. Paper documents, notices and contracts are available at your request. If you give your consent to use electronic documents, you can later change your mind and request a paper agreement instead.

Appointments

I agree to keep all scheduled appointments and be on time. If I cannot attend a scheduled session, I will call to cancel and/or reschedule. There will be no fee if phone message or conversation is received before 24 hours of the scheduled appointment time. I understand if I miss or cancel with less than 24 hours of notice, then I will be charged for the *full price* of the appointment.

Financial Policy

This is a statement of our financial policy. You understand that you are obligated to ensure that our fees are paid in full. You should verify your coverage before your visit with the clinician.

You agree that you will pay any deductible and co-payment or co-insurance as determined by your insurance plan. Those payments will be due at the time of service. Many insurance companies have additional requirements or stipulations that

may affect your coverage. You are responsible for any amounts not covered or payable by your insurance. If your insurance denies any part of your claim, you agree to be responsible to pay the full balance.

HIPAA Privacy Policies

Consent to Treatment

I have read through all the above information and have been clearly advised of my rights and responsibilities as a client of East End Nutrition, including the HIPAA Notice of Privacy Practices.

I understand these rights and responsibilities and agree to abide by them. I consent to treatment, and I understand I have a right to receive a copy of this form upon request. I also understand that I can withdraw this consent in writing and terminate at any time.

Signature

Please sign below if you agree to all policies described above.

_____

Date of birth: _____

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