

## Patient Information Form

Name: \_\_\_\_\_  
                     First  Middle  Last

Date of Birth: \_\_\_\_\_ Gender: M F SSN#: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Cell or Work Phone: (\_\_\_\_) \_\_\_\_\_

Email: \_\_\_\_\_

What is the best way to reach you if we have information about your appointment?

Circle one:    Home phone                      Work phone                      Cell phone                      Email

Is it okay to leave a message if you prefer to be reached by phone?    Yes    No

Who is your primary care provider? \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_

Is it okay to share information about your treatment plan with your primary care provider?    Yes    No

Are you currently seeking treatment from any other providers? Please list

Provider	Specialty
Example: Dr. Jane Doe	Chiropractor

Have you ever worked with a nutritionist or registered dietitian before?    Yes    No

**Reason For Visit (please list in order of importance)**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

**Please list any major illnesses, surgeries and/or hospitalizations**

Condition	When	Comment
Example: Knee surgery	2009	in physical therapy

**What medications are you taking now? Include non-prescription medications.**

Medication Name	Date Started	Dosage

**Are you allergic to any medications? If so, please list.**

**What nutritional supplements are you taking now?**

Supplement Name	Date Started	Dosage

**How often have you taken antibiotics?**

	Less than 5 times	More than 5 times
<b>Infancy/Childhood</b>		
<b>Teen</b>		
<b>Adulthood</b>		

**Have you ever taken probiotics?    Yes    No**

Please review this list of symptoms and circle “C” if you are currently experiencing the symptom, “P” if you experience it in the past and “N” if you’ve never experienced it.

**Head, Eyes, Ears,**

<b>Nose</b>	C	P	N
Headache	C	P	N
Migraines	C	P	N
Dizziness	C	P	N
Earaches	C	P	N
Ringing in ears	C	P	N
Fainting	C	P	N
Eye pain	C	P	N
Watery, itchy eyes	C	P	N
Dark circles under eyes	C	P	N
Vision problems	C	P	N
Stuffy nose	C	P	N
Sinus problems	C	P	N
Hay fever	C	P	N
Sneezing attacks	C	P	N

**Skin**

Acne	C	P	N
Hives	C	P	N
Rashes	C	P	N
Eczema	C	P	N
Dry skin	C	P	N

**Cardiovascular**

Angina/chest pain	C	P	N
Breathlessness	C	P	N
Heart attack	C	P	N
High blood pressure	C	P	N
Irregular pulse	C	P	N

**Digestion**

Nausea	C	P	N
Vomiting	C	P	N
Diarrhea	C	P	N
Constipation	C	P	N
Bloating	C	P	N
Excessive gas	C	P	N
Heartburn/reflux	C	P	N
Stomach pain	C	P	N

**Weight/Appetite**

Anorexia	C	P	N
Binge eating	C	P	N
Chronic dieting	C	P	N
Severe cravings	C	P	N
Overweight	C	P	N
Underweight	C	P	N

**Musculoskeletal**

Arthritis	C	P	N
Back pain	C	P	N
Joint pain	C	P	N
Muscle pain	C	P	N
Muscle weakness	C	P	N

**Mind, Mood, Energy**

Anxiety	C	P	N
Depression	C	P	N
Irritability	C	P	N
Difficulty concentrating	C	P	N
Poor memory	C	P	N
Fatigue/sluggishness	C	P	N
Hyperactivity	C	P	N
Restlessness	C	P	N
Learning disabilities	C	P	N
Feeling of hopelessness	C	P	N
Suicidal thoughts	C	P	N

**Sleep**

Insomnia	C	P	N
Sleep apnea	C	P	N
Difficulty falling asleep	C	P	N
Frequent waking	C	P	N
Difficulty waking	C	P	N
Night sweats	C	P	N

**Female Reproductive**

Breast cysts	C	P	N
Breast tenderness	C	P	N
Fibroids	C	P	N
Endometriosis	C	P	N
Ovarian cysts	C	P	N
Infertility	C	P	N
Low libido (sex drive)	C	P	N
Heavy periods	C	P	N
Skipped periods	C	P	N
Severe cramping	C	P	N
Sexual abuse	C	P	N
PMS	C	P	N
Menopause	C	P	N

**Male Reproductive**

Infertility	C	P	N
Low libido (sex drive)	C	P	N
Erectile dysfunction	C	P	N
Difficulty urinating	C	P	N
Enlarged prostate	C	P	N

**Diet History**

Are you currently following any special diet?

- Vegan       Blood type       South Beach  
 Vegetarian       Weight Watchers       Diabetic  
 Raw Foods       Jenny Craig       Gluten free/Celiac

Other: \_\_\_\_\_

Do you have any food allergies or intolerances?

\_\_\_\_\_  
\_\_\_\_\_

Are there certain foods you avoid?

\_\_\_\_\_  
\_\_\_\_\_

Are there certain foods you crave?

\_\_\_\_\_  
\_\_\_\_\_

**Typical Day's Diet**

List the foods you would typically eat for each meal and snack throughout the course of a normal day. Write "none" if you skip any of the meals or snacks.

	<b>Option 1</b>	<b>Option 2</b>
<b>Breakfast</b>		
<b>Snack</b>		
<b>Lunch</b>		
<b>Snack</b>		
<b>Dinner</b>		
<b>Snack</b>		

How many ounces of each of the beverages below do you drink through the course of a typical day? (8 ounces = 1 cup)

Water	_____ oz.	Soda (regular)	_____ oz.
Coffee (caffeinated)	_____ oz.	Soda (diet)	_____ oz.
Coffee (decaf)	_____ oz.	Fruit juice	_____ oz.
Tea (black or green)	_____ oz.	Energy drink	_____ oz.
Herbal Tea	_____ oz.	Crystal Light	_____ oz.
		Other	_____

How often do you consume the following beverages on a weekly basis?

Beer \_\_\_\_\_ bottles/cans per week  
 Wine \_\_\_\_\_ glasses per week  
 Hard Alcohol \_\_\_\_\_ drinks per week

**Lifestyle Habits**

Do you currently, or have you ever, smoked? Current Past No

Amount per day \_\_\_\_\_

Do you exercise regularly? Yes No

List your typical forms of exercise

Type of exercise	Times per week	Duration each time
Example: running	3 times per week	50 minutes each time

How many hours per week do you work? \_\_\_\_\_

Rank your stress on a scale from 1 to 10, with 10 being most stressed \_\_\_\_\_

What do you do for stress relief?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

How did you hear about us?

\_\_\_\_\_ Referral from doctor      \_\_\_\_\_ Insurance company      \_\_\_\_\_ Web site  
 \_\_\_\_\_ Friend/family member      \_\_\_\_\_ Google search      \_\_\_\_\_ Other

## Financial Policies

The policy of Michelle Babb, MS, RD, is to collect all payments or insurance information and co-pay at the time services are rendered. We accept cash or check for payment. We will bill all insurance companies with whom we are contracted. **It is your responsibility to contact your insurance company prior to your first office call so you know whether nutrition services are covered under your plan.**

All checks returned for non-sufficient funds will result in a \$25 service charge to collected by the next visit or within 30 days, whichever comes first.

If no payment is received on an account after 90 days, the account will be charged an interest rate of 15 percent. If there is still no payment made to the account after another 30 days, the account will be sent to a collection agency.

### Cancellations

Cancellations made less than 24 hours in advance will result in a fee of 25 percent of the cost of services. A no-show fee of **50 percent of the cost of services** will be charged for patients who fail to show up for scheduled appointments. Missed appointment charges are not covered by insurance.

I, \_\_\_\_\_, understand these policies and am willing to comply.  
(print full name)

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to patient (circle one):    Self    Parent    Legal Guardian    Spouse