Pre-Visit Form

I understand I will be charged for the full rate of each missed nutrition session if I do not call ahead with at least 24-hour notice, and these sessions will not be able to be made up in the future. I agree to pay for the full amount for the session at the time of service or, if a package deal, the full amount at the time of the first session (cash or personal check only; no credit cards). I agree to pay any amount that is not covered by my insurance. Nutrition appointments need to be completed within 6 months of purchase. Unused sessions will be lost.

I have read the above statements and understand the rescheduling protocol for my nutritional counseling sessions. Signature:_____ Date: _____

Name: _____ Address: _____

Phone: _____ Date of Birth: _____ Sex: _____

Email: _____ Food Allergies: _____

Reason for Appointment: _____

Medical History: _____

Physician: _____ Phone Number: _____

Insurance (Regence Subscribers only): _____

Diagnosis (if applicable): _____ Pertinent Labs: _____

Current Medications: _____ Supplements: _____

Age: _____ Height: _____ Weight: _____ Weight History: _____

_____

Exercise (type, duration, frequency): _____

_____

Work Status (if working – type of work, hours/wk): _____

Living Situation (shared meals? Eat alone?): _____

Energy Level (0-10): _____ Stress Level (0-10): _____

Alcohol (quantity, frequency): _____ Tobacco (cigarettes/day): _____ Other

Drugs: _____ Average hours sleep: _____ How is your appetite: _____

Who shops for food and where? _____

If cook, who does it? _____ How often eat out in a week (where)? _____

Food cravings: _____ Food dislikes: _____

Short-term goal(s): _____

Long-term goal(s): _____

What challenges do you foresee in achieving your goals? _____

_____

Any other information: _____