Debra A. Blair, R.D.N., C.D.E., L.L.C.
CLINICAL NUTRITIONIST

Name: ______________________________ Date: ____________________

Primary Care Physician: ____________________ Phone: ____________________

Referring Physician: ______________________ Phone: ____________________

Reason for visit: ____

Height: _______________ Weight: __________________ Age: ___________

Please check all of the following conditions that apply to you:

___Hypertension ___Heart Disease ___Stroke ___Diabetes ___Asthma

___Emphysema ___Hepatitis ___HIV ___Hypothyroid ___Colitis

___Kidney Failure ___Liver Failure ___Blood Clots ___Poor Circulation

___Gastric Ulcers ___Prostate

___Cancer Specific Type and Treatment: __________________________________

___Other (Please Specify): ____

Please list all current medications, dose and frequency: __________________________

____

____

Allergies: ____

Previous diets you have been on:____

____

Do you smoke? Y / N How many/day? ______ For how long: ____________________

Do you drink alcohol: Y / N How much and how often? _______________________

What two main food or eating questions do you want answered today?
1. ______________________________
2. ______________________________

What have you been told about food, eating and diabetes?
____

Please tell us what you eat in a typical day.
Breakfast or first meal: ______________________________ Time: ________
Snack: ______________________________ Time: ________
Lunch or second meal: ______________________________ Time: ________
Snack: ______________________________ Time: ________
Dinner or second meal: ______________________________ Time: ________
Snack: ______________________________ Time: ________

How would you describe your appetite? ______ Good ______Fair ______Poor
Who prepares meals in your home? ______________________________
How many meals do you eat away from home each week? ______________________________

What food planning method do you use?
______ None ______Carbohydrate Counting ______Exchange Lists ______Calorie Counting
______Healthy Eating Using the Food Pyramid

How much of the time are you able to follow it:
______0% - 25% ______25%-50% ______50% - 75% ______75% - 100%

Has your weight changed in the last year? ______Yes ______No ______Gained ______Lost
What do you think is a realist weight for you? __________

Do you take vitamins or herbal supplements? ______Yes ______No
If yes, please list. ______________________________

Do you exercise? ______Yes ______No
What do you do: ______________________________

If you do not exercise now, what activities would you consider: ______________________________

Patient Information

Last Name: ______________________ First Name: ______________________ MI: ____

Address: ____

City:________________State: __________Zip: __________

Home Phone: ______________________ Work Phone: ______________________

Cell Phone: ______________________ Email: ______________________

Date of Birth: ______________________ Age: ____________ SS#: ____________

Employer: ______________________ Address: ______________________

Marital Status: Single Married Separated Divorced Widowed

Insurance Information

Insurance Carrier: ____

Subscriber: ____

Policy Number: ______________________ Group #: ______________________

Secondary Insurance Carrier: ____

Subscriber: ____

Policy Number: ______________________ Group #: ______________________

Please read and sign below:

I hereby authorize Debra A. Blair, R.D.N., C.D.E., to furnish information concerning my treatment to the insurance carriers. I also hereby assign to Debra A. Blair R.D.N., C.D.E., payment for services rendered to myself. I understand that I will be responsible for any amount not covered by my insurance. If I have no insurance, I will be responsible for payment in full at the time of service.

Patient Signature: ______________________________ Date: ______________

Privacy Consent

We require your consent to use and disclose your protected health information to carry out treatment, payment, and health care operations. If you would like a more detailed description of such uses and disclosures, please refer to the *Notice of Privacy Practices*.

You have the right to review the *Notice of Privacy Practices* before signing this consent form. The terms of the *Notice of Privacy Practices* may change from time to time. You can get a copy of the latest *Notice of Privacy Practices* by contacting our office. We also will post a copy of our current *Notice of Privacy Practices* in our office.

You have the right to request that we restrict how we use or disclose protected health information to carry out treatment, payment, or health care operations. We do not have to agree to such requests, but must honor the requests to which we agree.

You have the right to revoke this consent in writing, and the revocation will become effective except to the extent that we acted in reliance on your consent.

By signing below, you hereby consent to our use of your protected health information to carryout out treatment, payment, and health care operations, and acknowledge receipt of a copy of this consent if requested.

Printed name: ______________________________

Signature: ______________________________ Date: ______________

Please check one: You can ( )/cannot ( ) leave a message on my home phone/cell phone.
It is acceptable to contact me by e-mail: Yes ( )/No ( )

Note: E-mail contact is for your benefit only. Information is not shared without additional consent from you. However, e-mail exchange is not inherently secure.