Integrative Weight Management
Medical Art Center, LLC
950 State Route 35, Middletown, NJ 07748
732-888-0017
Fax 732-888-0097

Date:_____

NUTRITION ASSESSMENT FORM

Name:_____ DOB:_____ Age:_____ Gender: M/F Ht:_____

Address:_____

Phone:_____Email:_____

Occupation:_____ Retired: Y/N if Yes, Date:_____

Highest Level of Education:_____ Marital Status:_____

Please List the people in your household and their relationships to you:

_____

_____

General Health Information

Primary Physician Name (other than Dr. Bazerbashi):_____

Phone:_____ Fax:_____

How do you rate your health? (Circle one) Poor Fair Good Excellent

Explain:_____

Past Medical History

Please circle if you EVER had or CURRENTLY have any of the following medical conditions:

Diabetes	High Blood Pressure	Stroke	Fatty Liver	Kidney Disease	Back pain
Swollen feet/legs	Heartburn/GERD	Hip pain	Knee pain	Erectile dysfunction	Arthritis
Stomach ulcers	Heart valve disorder	Anemia	Sleep apnea	Heart Palpitations	Obesity
High Cholesterol	High Blood sugar	Anxiety	Depression	Diverticuliosis/titus	IBS
Low blood sugar	Irregular Periods	Gout	PCOS		

Other:_____

Have you ever been diagnosed or treated by a medical professional for eating disorders such as Anorexia, Bulimia, Binge Eating disorder? Y/N if you answered yes, please explain:

_____

_____

Surgery History

Any surgery? Y/N: if yes, please specify type of surgery and date:

_____

_____

Family History

	Age	**Healthy/disease**	**Cause of death**	**Overweight?**
Mother:				
Father:				
Sisters:				
Brothers:				

Do you have a family history of the following? (Circle all that apply)

High Blood Pressure	High cholesterol	Diabetes	Thyroid disease
Cancer	Obesity	Heart disease	Other:_____

Is your spouse, fiancé or partner overweight/obese? **Y/N**

Are your children overweight/obese? **Y/N**

Is anyone in your household on any "special" diet? **Y/N?** if yes, Explain:

_____

_____

Nutrition Evaluation

Are you currently on any medications? Please list:_____

_____

_____

_____

Do you take any vitamins, supplements, herbs, etc? Please list:_____

_____

_____

Describe your bowel movements (how many per day, consistency: pebble-like, smooth, watery, constipation, diarrhea)_____

_____

Do you smoke? **Y/N** If yes, how many per day?_____

Present Weight:_____lbs Height:_____ Desired weight:_____

If Applicable, In what time frame would you like to reach your desired weight?_____

Birth weight:_____Weight at 20 yrs old:_____ Weight 1 yr ago:_____

What is the reason for the visit today?_____

If Applicable, Please list any diets you have been on, including dates/results of any weight loss:

_____

_____

Describe your daily routine:

Work hours:_____

Weekends_____

Hobbies:_____other:_____

How often do you eat out?:_____

Bring food in?_____

Types of foods eaten out/brought in?_____

How often to you bring food to work:_____

What restaurants do you eat at frequently?_____

How often do you eat "fast foods"?_____

Who plans/cooks meals in your household?:_____

Who is responsible for food shopping?_____

Please circle all that apply: Is food purchased at large supermarkets, specialty market, farmers market, convenience store, other?_____

Do you read food labels? **Y/N**

What ingredients do you look for?_____

Do you generally do things while eating? (i.e. read, watch television, work, etc): Y/N Explain:

_____

_____

Food allergies/intolerances:_____

Favorite foods:_____

Food dislikes:_____

Do you have food cravings? **Y/N** Please indicate types of foods

_____

_____

Do you drink the following? (please circle all that apply and include oz. per day):

Water_____oz Coffee_____oz Tea_____oz Decaf_____oz Soda_____oz

Diet soda_____oz Wine/beer/other_____oz

Do you use sugar/butter/margarine substitute?:_____

Types:_____

What are your "WORST" food habits?: _____

What are your "BEST" food habits?: _____

Snack Habits (Give examples of foods you frequently snack on, and when):

_____

_____

Do you think you are currently undergoing a stressful situation or an emotional upset?

Y/N if you answered yes, please explain:_____

_____

When under a stressful situation at work or family related, do you tend to eat more?

Y/N if you answered yes, please explain:_____

_____

Physical Activity Information

What is the most physically active thing you do in an average day?_____

_____

What , if any, regular exercises do you do? How often and for how long do you participate

_____

_____

Do you know of any reasons why you should not do any physical activity? If yes, please explain:

_____

_____

How many hours of sleep do you get per week night?_____ Weekends?_____

Do you wake up during the night? **Y/N** Explain:

_____

_____

How soon do you eat from the time you wake up? Describe:_____

_____

_____

On a scale of 1-10 with 10 being the most hungry, how would you rate your hunger levels before meals?_____ Which time of the day and/or meal are you most hungry for?_____

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HIPAA Privacy Practices Summary and Acknowledgement for Nutrition Services

Federal regulations (HIPAA) now require medical offices to formally inform patients to their rights concerning privacy of their medical information. You are asked to sign the bottom of this page to acknowledge that we have offered you a full description of these policies and that you understand your rights in this matter. What follows is a brief summary of the HIPPA policies. Refusal to sign will not affect your medical care in any way.

1. It is our obligation to protect your health information and privacy. That means that we cannot and will not release any information to anyone not involved in either your health care or management.
2. We are allowed, even without your formal authorization, to disclose relevant information for managing your care. This includes other treating physicians, insurance payers, or governmental health agencies when required by law.
3. We are also allowed to disclose relevant health information for the following possible agencies:
    i. Public Health Departments
    ii. Health Oversight Agencies
    iii. Food and Drug Administration
    iv. Law Enforcement
    v. Coroners
    vi. Workers Compensation
    vii. Parents of Minors
4. You have the right to object to disclosure of your health information, even to any of the above mentioned. You will be required to submit this is writing to the Privacy Officer at this office. We have the right to deny your request, but you have the right to appeal.
5. You have the right to inspect your records. You have the right to challenge the accuracy of your records.
6. If you feel your rights have been violated or wish further information, you may submit a written complaint or request to our Privacy Officer.

I have read the above and have been given access to the complete Privacy Practice Policies. I understand my rights and acknowledge the above summary.

_____ _____

Patient Signature Date

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Authorization To Communicate Form

I hereby authorize the Medical Art Center Registered Dietitians to release/receive my medical nutrition information to the following person and/or doctors:

1. _____
Relationship to Patient:_____
Date:_____

2. _____
Relationship to Patient:_____
Date:_____

3. _____
Relationship to Patient:_____
Date:_____

4. _____
Relationship to Patient:_____
Date:_____

Patient Name_____Signature_____

Date_____

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Dear Patient/Client:

Thank you for allowing me to help you improve your diet and lifestyle. It takes much effort and determination to alert behaviors related to eating, exercise, and overall lifestyle improvement. In an effort to maximize these changes I would like to emphasize that they will be more likely to occur with sustained interaction between the health care provider (me) and the client seeking to change or improve their diet and lifestyle. Each meeting will help to troubleshoot any obstacles a patient/client may be encountering, help you identify your successes, and help one to find/reach their goals in a more timely fashion.

It has been my experience that 4-6 visits over a 6-12 month period of time will offer a more favorable outcome for you and your diet/lifestyle goals.

These positive changes will be **much less likely to occur with one single visit.** I cannot emphasize enough the importance of regular contact, either by phone, fax, or email as well as the need to physically come in and discuss your progress and understanding of what a healthy diet means for you based on your medical history and current health status.

Please help me to help you by making and keeping follow-up appointments.

A block of time has been reserved for you in order to facilitate positive changes in diet/lifestyle, it is extremely important for you to receive the attention that you deserve.

There is a 72-hour cancellation policy on ALL nutrition counseling appointments.
If you fail to cancel within 72 hours, a $50 fee will be charged. If you fail to show up to your appointment and do not communicate with the office (No Show) a $75 fee will be charged.

I understand that my eating, exercise, and lifestyle habits will be more likely to improve with continuous contact between myself and a health care provider trained in skills that will help me to facilitate these changes.

I,_____, am aware that I need to provide 72 hours notice that I will be unable to attend the appointment. I authorize Medical Art Center to charge my credit card if I fail to provide notice and/or no show for the appointment.

Credit Card Information

Credit Card:_____ Card Number:_____ Exp Date:_____

Security Code:_____

Patient/Client Name:_____Date_____

Patient/Client Signature_____Witness_____