Peterson Nutrition & Fitness
2200 Pump Rd., Suite 22
Richmond, Virginia 23233
804-440-3110 Fax: 804-377-9690

CLIENT INFORMATION & REGISTRATION FORM: Please complete the following for identified patient:

Patient's Name: _____
(First) (M.I.) (Last)

Address: _____ City/Zip: _____

Social Security #: – – Date of Birth: ____/ ____/ _____ Age: _____

Sex: _____ Educational Level: _____ Marital Status: _____

Employer/School: _____ Occupation: _____

Home Phone: _____ May I contact you at home? YES_____ NO_____

Work Phone: _____ May I contact you at work? YES_____ NO_____

Cell Phone: _____ May I contact you on your cell? YES_____ NO_____

Email: _____ Referred by: _____

I give permission to contact the following person if necessary:

Emergency Contact: _____ Relationship: _____ Phone: _____

Primary Care Physician: _____ Phone: _____

It is difficult to determine how many sessions will be needed. Please discuss with me if our sessions are meeting your needs and goals. When your goals have been met, we will discuss termination. If our sessions are not meeting your needs, we can discuss other resources that might be beneficial to you.

I AGREE TO THE FOLLOWING:

I hereby authorize Elisabeth Peterson, Registered Dietitian & AFAA Certified Personal Trainer, to render medical nutrition therapy to family members & myself. I also authorize Ms. Peterson to release any information regarding my counseling to my primary care physician, referring physician and my therapist.

In accordance with HIPAA guidelines, I hereby grant consent to Peterson Nutrition & Fitness to use and disclose all information regarding my medical history. A copy of the HIPPA guidelines is available to me, at my request, from Peterson Nutrition & Fitness. By signing I acknowledge that I have been provided a copy of the HIPPA guidelines to read. If at anytime I want to revoke authorization to release information, I must do so in writing.

I understand that Ms. Peterson's initial consultation visit (50 minutes) are $115 and follow-up visits (25 minutes) are $60 and I am responsible for all charges arising from treatment at the time of service. I accept that no-shows and cancellations made less than 24-hours prior to appointment time are subject to charges equaling cost of standard visit. I will pay $35 for any "returned check," and 21% service charge. If this contract is referred to an attorney or collection agency for collection, I agree to pay all attorney and collection fees and court costs incurred by Peterson Nutrition & Fitness. I understand that Medicare will not cover these services, and that Peterson Nutrition & Fitness is not a Medicare provider, and therefore I cannot submit claims to Medicare for services rendered for reimbursement.

I certify that this information is correct to the best of my knowledge.

Signature: _____ Date: _____

Personal Data

Name: _____ Date: _____

Housing: _____. Date of last: Medical Exam: _____ Medication Change: _____ Dental Exam: _____
(I live with)

Allergies: _____

List current medications: _____

List food and/or vitamin/mineral supplements: _____

Weight History - Answer all that apply

Present Wt: _____ Wt at birth: _____ Wt in preschool: _____ Wt at age 12: _____ , age 20 _____

age 30 _____ , age 40 _____ , age 50 _____, age 60 _____, on Wedding day _____ (yr. _____). Desired Wt: _____

Maximum: _____/_____/_____ Lowest: _____/_____/_____ Desired: _____/_____/_____
wt. date lasted wt. date lasted wt. date lasted

I weigh myself: _____ times a: (circle one) day week month Where do you weigh yourself? _____

History - Indicate as follows: "I"- Self , "M"- Mother, "F"- Father, "S"- Sibling and "G"- Grandparents

Family Medical

Arthritis		Dizziness		Heart trouble		Kidney trouble	
Asthma		Epilepsy		Headaches		Obesity	
Diabetes		Fatigue		Hypertension		Ulcers	

Family Social/Behavioral

Alcoholism		Depression		Nightmares		Rape	
Anorexia Nervosa		Drug Addiction		Phobias		Self Mutilation	
Bulimia Nervosa		Emotional Abuse		Physical Abuse		Sexual Abuse	
Binge Eating		Incest		Psychotherapy		Stealing	
Compulsive Behaviors		Mood Swings		Psychiatric Hospitalization		Secretive Behaviors	

Sexual Orientation

Heterosexual _____ Homosexual _____ Bisexual _____ Sexually Inactive _____ Unaware of _____

Physical Symptoms - Indicate as follows: "Y" – Yes or leave blank if No. If yes, please give details.

Do you experience gastrointestinal problems? ___. Diarrhea___, Constipation ___, Abdominal Pain/Bloating ___, Nausea ____, Reflux____

Details: _____

Have you ever vomited blood? _____ Details:_____

Have you observed changes in your hair _____, nails _____, teeth _____,skin _____,vision _____ as a result of your eating behaviors?____

Details:_____

Does your eating or restricting effect your energy level _____, concentration _____, vision _____, or ability to sleep?_____

Details: _____

Have you ever been hospitalized for an eating disorder? _____. How often? _____. Dates: _____

For how long? _____ Where? _____

How do you view that experience? _____

Have you ever been hospitalized for another reason? Details: _____

Females only: Age _____, Weight _____ at time of first menses. Are you on prescribed birth control? _____ Type _____

Date of your last menstrual cycle _____. Number of days between periods _____. Number of days period lasts _____

Diet History

Age you first started dieting? _____ Weight at beginning _____ Weight at end _____

Why did you begin to diet? _____

Who influenced your desire to lose weight? _____

Exercise History - Fill in either Y – Yes or N – No. If yes, give details.

Are you currently exercising? _____

Details: Type of exercise Minutes per day Days per week

_____

_____

_____

Do you or have you ever participated in intramurals, Olympic competition, professional sport or dance? _____

Details: Type of participation Minutes per day Days per week

_____

_____

_____

Eating Behaviors: In each blank, place one letter that best corresponds with your eating behavior.

A – Always U - Usually S - Sometimes R - Rarely N - Never

1. I eat 1, 2, 3 (circle one) meals each day. _____
2. I eat when I am hungry. _____
3. I eat 3 meals with 1, 2, 3 (circle one) snacks. _____
4. I rigidly restrict my food intake. _____
5. I restrict in the day and overeat in the evening. _____
6. I restrict the intake of specific foods. _____

   List:_____
7. I restricted my intake at specific times. _____

   List:_____
8. I binge without purging. _____
9. I graze all day long. _____
10. I go to sleep feeling stuffed ____, empty ____, satisfied _____.
11. Once I start eating, I don't stop. _____
12. I binge and then I exercise excessively ____, vomit _____ laxatives ___, restrict ___, take diuretics ___, diet pills____.
13. When I don't binge, I exercise excessively ____, vomit _____ laxatives ___, restrict ___, take diuretics ___, diet pills____.
14. I eat whatever I want ____. Without regret ____.
15. I eat whatever I want ____. With regret _____.
16. I eat whatever I want, and then exercise excessively ____, vomit _____, use laxatives ____, take diuretics ____.

Behavior Frequency – Number of times

	Currently			In the Past			
	Per day	Per week	Per Month	Maximum	Date	Minimum	Date
Exercise							
Vomit							
Restrict							
Overeat/binge							
Take diuretics							
Take diet pills							
Take laxatives							
Drink coffee/tea (cups)							
Drink caffeinated beverages							
Drink Water							
Smoke Cigarettes							
Alcohol Intake							

Have your worked with a dietitian or nutritionist? Yes ____ No____. If yes, who _____ when _____

What are your goals in working with a dietitian now? _____

_____

_____

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Client Authorization for Use/Disclosure of Protected Health Care Information

Client Name: _____ SSN: _____

I request and authorize Elisabeth C. Peterson, RD, to share (release to and obtain from) health care information of the patient named above with:

1.
Name: _____ eff. Date: _____
(Name of individual or entity to receive the information)

Address: _____

Telephone: _____ Fax: _____

2.
Name: _____ eff. Date: _____
(Name of individual or entity to receive the information)

Address: _____

Telephone: _____ Fax: _____

3.
Name: _____ eff. Date: _____
(Name of individual or entity to receive the information)

Address: _____

Telephone: _____ Fax: _____

THIS AUTHORIZATION EXPIRES WHEN THE ABOVE NAMED CLIENT OR PERSONAL REPRESENTATIVE REVOKES THIS AUTHORIZATION IN WRITING.

I understand that I have the right to revoke this authorization at any time. However, my revocation will not have any affect on any actions Elisabeth C. Peterson, RD, took before she received the revocation.

I understand that once Elisabeth C. Peterson, RD, releases this information, the information may be subject to redisclosure by the party receiving the information and may no longer be protected by federal or state law.

Signature of Client or Client's Representative: _____ Date: _____

Printed name of Client's Representative: _____

Relationship to Client: _____