



Peterson Nutrition & Fitness

2200 Pump Rd., Suite 220
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 \$100 and follow-up visits (25 minutes) are \$55 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)
Height: _____ 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

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

Have you 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: _____