Peterson Nutrition & Fitness
PO Box 551, Irvington, VA 22480
804-440-3110 www.petersonnutriton.com

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: _____

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 benefit you.

I AGREE TO THE FOLLOWING:

I hereby authorize Elisabeth Peterson, Registered Dietitian Nutritionist, Certified Eating Disorder Specialist & 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 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 charge 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

Preferred Name: _____

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

Allergies: _____

List current medications: _____

List food and/or vitamin/mineral supplements: _____

Sex assigned at birth _____

Identifiers

Gender Identity _____ Sexuality _____ Pronouns _____ Other _____

Cultural

Ethnic or racial identities: _____

Cultures to be respectful of that impact your relationship with food: _____

_____

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

Family Medical

Arthritis	_____	Cholesterol	_____	Heart disease	_____	PCOS	_____
Asthma	_____	Diabetes	_____	Headaches	_____	Stroke	_____
Cancer	_____	GI	_____	Hypertension	_____	Other	_____

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	_____

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: _____

For those who have or have had a uterus: Age _____, Weight _____ at time of first menses.

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

Are you on prescribed birth control? _____ Type _____ Have there been inconsistencies with your menstrual cycle?_____

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: _____

Diet History

Tell me about your dieting history: Why did you begin to diet? Who influenced your desire to diet? What determines how much you eat? Do you have certain eating rules that dictate what, when and/or how you eat? What are your food rules? _____

_____

_____

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							

Physical Activity & Movement - *If you are not able-bodied, please only answer these questions as you feel comfortable and if it would be helpful for both you and I to initially discuss.

Have you ever maintained a consistent physical activity routine or regimen? _____
Tell me about your relationship to physical activity in the past: _____

_____

Are you currently moving your body on a regular basis? If yes, describe: _____

_____

Tell me how you currently feel about in the idea of movement as a part of your lifestyle: _____

_____

Are there any injuries or physical limitation you have that prevent you from participating in and enjoying physical activity? If yes, please explain: _____

Goals

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, RDN, CEDS-C 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, RDN, CEDS-C took before she received the revocation.

I understand that once Elisabeth C. Peterson, RDN, CEDS-C releases this information, the information may be subject to re-disclosure 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: _____