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 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 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? ___________________________

____

____

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

Client Authorization for Use/Disclosure of Protected Health Care Information

Client Name: ______________________________ SSN: ____________________

I request and authorize Elisabeth C. Peterson, RDN, CEDRD-S 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, CEDRD-S took before she received the revocation.

I understand that once Elisabeth C. Peterson, RDN, CEDRD-S 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: ______________________________