# PAGE 1: INITIAL HISTORY AND NUTRITION ASSESSMENT

**To be filled out by client**

Name: Date:
Address:
City: State: Zip: Age: Sex:
Home Phone: Work Phone: Date of Birth:
Email:

**Reserved for Dietitian**

Referral Source:

Insurance Co: Policy Number:
Subscriber's Name: Subscriber's SSN:
Ins. I.D. Number: Employer or Subscriber:

Additional Insurance Information:

Primary Physician: Date of Last Check-up:
Reason for Seeing Dietitian:
How long had this condition/disease?
List any symptoms associated with this condition:
How has your life been effected by your medical condition?

Diagnosis/Chief Complaint:

**Personal Medical History:**
**Place a check mark in front of the conditions you have or have had**

- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Hyperlipidemia
- ☐ Cancer
- ☐ Lung Problems
- ☐ Food Allergies
- ☐ Other Medical Conditions _____
- ☐ Diabetes
- ☐ Obesity
- ☐ Arthritis
- ☐ Anemia
- ☐ Chewing Problems
- ☐ Food Sensitivities
- ☐ Ulcer
- ☐ Gallbladder Disorder
- ☐ Constipation
- ☐ Diarrhea
- ☐ Gastrointestinal Problems
- ☐ Other Allergies

Medical History:

**Family Medical History: Check conditions that apply to your blood relatives**

- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Hyperlipidemia
- ☐ Cancer
- ☐ Lung Problems
- ☐ Food Allergies
- ☐ Other Medical Conditions_____
- ☐ Diabetes
- ☐ Obesity
- ☐ Arthritis
- ☐ Anemia
- ☐ Chewing Problems
- ☐ Food Sensitivities
- ☐ Ulcer
- ☐ Gallbladder Disorder
- ☐ Constipation
- ☐ Diarrhea
- ☐ Gastrointestinal Problems
- ☐ Other Allergies

Family Medical History:

Quality of Life:

**Patient Behavior**

| | 0=N/A | 1=Never | 2=Rarely | 3=Sometimes | 4=Often | 5=Occasionally |
|---|---|---|---|---|---|---|
| **Excessive evening consumption** | | | | | | |
| **Portion Size** control appropriately | | | | | | |
| **Meal Replacements** Uses appropriately | | | | | | |
| **Food Guide Pyramid** Eats accordingly to | | | | | | |
| Sets **realistic wt. reduction goal** | | | | | | |
| Gets **appropriate physical activity** | | | | | | |

## PAGE 2: INITIAL HISTORY AND NUTRITION ASSESSMENT

| **To be filled out by client** | **Reserved for Dietitian** |
|---|---|
| Name:<br>Marital Status: ____Single ___Married ____ Divorced/Separated ____ Widowed<br>List seeing, hearing, other impairment: Last Grade Completed:<br>Occupation: Number of persons in household:<br>Names Relationship Age | Family & Social History |
| Anyone else in household on special foods or meal plan?<br>If so, what type of foods or meal plan?<br>Who cooks for you? How often do you eat at home per week?<br>Name 3 or more foods you regularly prepare at home?<br><br>How often do you eat out each week?<br><br>Where you eat out What you order to eat<br><br>How many meals/snacks do you eat a day? How often do you eat breakfast a week? | Meal Plans:<br><br>Servings Per Day:<br>Dairy<br>Veg.<br>Fruit<br>Meat<br>Starch<br>Fat<br>Sweets |
| List any foods you are allergic to:<br><br>Food dislikes or foods you have problem eating (gas, stomach pain, etc.) | Problem Foods: |
| Height: Present Weight: Usual Weight: Goal Weight:<br>Pounds gained this year Pounds lost this year<br>Are you on or have been on a special diet? What type?<br>Where did you receive your information about the diet?<br>Did you stay on your meal plan? How long?<br>Did you use the information you learned?<br>List the problems you had trying to follow your meal plan.<br><br>What beverages do you drink each day?<br>What types of diet foods are you using?<br>Are you using any foods from a weight loss program?<br><br>List any vitamin/mineral or health supplements you are taking. | Height:<br><br>Weight:<br><br>Barriers:<br><br>Supplements: |
| List all medications you are taking, time of day, and amounts (use back if needed)<br><br>Alcohol Intake: _____Drinks _____Per Day _____Per Week Type:<br><br>Tobacco Intake: _____None Smoker _____Quit smoking recently _____Pipe or Cigar<br><br>_____Packs of Cigarettes a Day _____Chewing Tobacco | Medications:<br><br>Possible Drug/Nutrient Interactions:<br><br>Substances: |

## PAGE 3: INITIAL HISTORY AND NUTRITION ASSESSMENT

| **To be filled out by client**<br>Name: | **Reserved for Dietitian** |
|---|---|
| Exercise Regularly? If so, what types?<br>Minutes/Day_____ Days/week_____<br>Moderate _____ Total number of hours per week _____<br>or<br>Vigorous_____<br>Willing to increase? Injuries or limitations?<br>Other problems | Exercise: |
| Self Assessment of Stress Level: ____ High _____ Moderate _____ Low<br>Personality Type: ____ impatient, time-oriented, competitive<br>____ Usually somewhat relaxed, sometimes anxious _____ Relaxed, easy going<br>Any severe personal problems in the past 12 months? (such as death of family member, marital problems, divorce, job changed, accidents, law suits, serious family problems, ill health)<br><br>Relaxation Techniques Practiced? Which ones? | Stress Assessment |
| Fasting Glucose g/dL _____ HgA1C _____<br>Can you monitor your Blood Glucose, if applicable?<br>If currently: Time of Day Times per Week<br>Any Problems?<br>Can you monitor your Blood Pressure, if applicable? | Blood Glucose Monitoring:<br><br>Blood Pressure Monitoring: |
| What are you goals?<br><br>What help would you particularly like from the Dietitian? | Motivation:<br><br>Expectations: |

**This space is reserved for Medical Provider**

| Date: | | | | | | |
|---|---|---|---|---|---|---|
| Blood pressure | | | | | | |
| Total Cholesterol | | | | | | |
| LDL | | | | | | |
| HDL | | | | | | |
| Triglyceride | | | | | | |
| Waist Circumference | | | | | | |
| Hip Circumference | | | | | | |
| Waist-Hip Ratio | | | | | | |
| BMI: | | | | | | |

B.A. Hughes & Associates, August 18, 2010

This information I give to the best of my knowledge:

Client's Signature:_____ Date:_____

# B.A. Hughes & Associates

**4208 Galax Drive, Raleigh, NC 27612**
**919-787-2949**
*Updated 8.27.10*

## NEW PATIENT INFORMATION

### APPOINTMENT:

Individual appointments are scheduled for a specific time period. Most first time appointments are scheduled for 1.5 hours. Allow from 45 minutes to one hour for follow up visits. Each patient should count on at least 2 follow up visits. BCBSNC plans provide 6 free visits. We phone your insurance to determine the number of visits you are permitted. Most plans permit number of visits based on "medical necessity." PLEASE CALL OR E-MAIL US 24 HOURS IN ADVANCE FOR CANCELLATIONS.

### MEDICAL INSURANCE:

B.A. Hughes & Associates, LLC, has been credentialed to provide medical nutrition therapy by AETNA, CIGNA Healthcare, Blue Cross Blue Shield of North Carolina (Blue Advantage, Blue Care and Blue Options), Federal Blue Cross Blue Shield, and some other state Blue Cross Blue Shield plans.

THE NORTH CAROLINA STATE HEALTH PLAN (Medco) will reimburse for individuals with diabetes (6 visits free) and all other state employees or retirees 4 visits plus a $25 copayment.

MEDICARE coverage applies for medical nutrition therapy for diabetes and non-end-stage renal diseases.

### PAYMENT:

B.A. Hughes & Associates will file for reimbursement from your insurance company if it is one listed above. Co-payment or payment by clients without insurance is expected at time of appointment. Checks are to be made payable to B.A.Hughes & Associates. Credit cards are **NOT** accepted. If payment of $200 for the first visit and $100 for follow up visits is a concern, **PLEASE** negotiate with us at time of initial contact. **EXPECT TO BE BILLED $30 FOR MISSED APPOINTMENTS UNLESS WE ARE NOTIFIED OF CANCELLATIONS AT LEAST 24 HOURS IN ADVANCE.**

I hereby acknowledge responsibility for this account and assume and guarantee payments of all charges against this account as they accrue.

Signature of responsible party/patient_____

Date_____