Gail Posner's

Healthy Ways Nutrition Counseling

Nutrition Guidance with Registered Dietitians

248-855-4558 / www.GailPosner.com

NUTRITION HISTORY QUESTIONNAIRE

Name _____ Date _____

Address _____
(Street) (City) (State) (Zip)

Phone (_____)_____ (_____)_____
(Home) (Business)

E-mail address: _____

Sex _____ Weight _____ Height _____ Age _____

Primary Physician(s): _____
(Name) (Address)

OB/GYN (if appropriate) _____
(Name) (Address)

1) Are you on a special diet? If yes, please describe:

2) What do you feel is your ideal weight? _____

3) Approximately what was your weight: (if 25 years old or older)

Last year: _____ Five years ago: _____ Ten years ago: _____

4) Please describe briefly any previous weight-loss diets that you have tried and approximately how many years ago you tried them:

5) Do you have any food allergies? If yes, please describe:

6) Are you taking any special diet supplements or vitamins? If yes, please describe:

7) Are you taking any medications? If yes, please list medications and please describe why you are taking each drug:

8) Do you have any of the following conditions? (Please check):

Diabetes	_____	Renal Disease	_____	Breast-feeding	_____
High blood pressure	_____	Liver Disease	_____	Hyper/hypo thyroid	_____
Heart Disease	_____	Pregnant	_____	Other	_____

9) Please list your blood value levels for the following, if you know them:

Blood Cholesterol	_____	Blood Sugar	_____
Triglycerides	_____	Blood Pressure	_____

10) Who referred you to, or how did you hear about, Gail Posner or Healthy Ways Nutrition Counseling?

PLEASE READ CAREFULLY, AND FILL IN THE BLANK, BEFORE SIGNING:

I understand that the dietitians at Healthy Ways Nutrition Counseling are not physicians and that they are not trained to diagnose and treat medical problems. I will contact my physician within _____ days after signing this document, to discuss the dietary and exercise advice given by the dietitian. I agree that I must keep my physician informed of my medical condition and that Healthy Ways Nutrition Counseling has no obligation to discuss my eating plan or condition with my physician. I agree to immediately notify the dietitian of any changes in my medical condition.

I understand that my ability to change my weight depends largely upon my own behavior and Healthy Ways Nutrition Counseling has made NO WARRANTIES regarding its program or the results I should get under the program.

I understand that, unless I am ill or give at least 72 hours' notice, Healthy Ways Nutrition Counseling will charge me for canceled appointments.

_____

(Signature)

NOTICE OF PRIVACY PRACTICES

Our practice is required to: Maintain the privacy of your health informat5ion. Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you. Abide by the terms of this agreement. Notify you if we are unable to agree to a requested restriction, and accommodate reasonable requests you may have to communicate your health information. We will not use or disclose your health information in a manner other than for treatment, and it will be shared with other health care professionals involved in your care. We will provide your other physicians or subsequent health care providers (when applicable) with copies of various reports that should assist them in treating you.

I understand my privacy rights as a patient.

_____ _____

Signature **Print Name**

Date: _____/_____/_____