Elisabeth
PETERSON NUTRITION & FITNESS

Peterson Nutrition & Fitness
2200 Pump Rd., Suite 220
Richmond, Virginia 23233
804-440-3110

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 & 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

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: ______________________________

Biological sex ______

Identifiers

Gender Identity ________ Sexuality ________ Preferred Pronouns ______ Other ________

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	______

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

	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							

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, 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: ______________________________