Print Form

NUTRITIONAL SCREENING FORM

Client Information

Social Security Number: _____

Client: _____ Height: _____

Parent/Guardian (if applicable):_____ Weight: _____

Address: _____ Date of Birth: _____

_____

_____ Sex: M ___ F ___

Marital Status: Single ___ Married ___ Divorced ___ Widowed ___ Life Partner ___

Phone: (H) _____ (W) _____ (Cell) _____

E-mail Address _____

Business Address: _____

_____

_____

Occupation: _____

Referred By: _____

Emergency Contact: Name: _____

Phone: _____

Primary Physician: _____

Phone Number: _____

Specialist Physician: _____

Phone Number: _____

Client Insurance Information

Insurance: _____

ID: _____ Group ID: _____

Insurance Company Phone Number: _____

Insurance Company Mailing Address: _____

_____

_____

Primary Holder of Insurance Information (If different from above)

Name: _____ Date of Birth: _____

Address: _____

_____

_____

Phone: _____

ID: _____ Group ID: _____

Employer: _____

- Pertinent Diagnosis: _____
- Food Allergies: _____
- Currently prescribed medications and supplements: _____

_____

- Have you or your child ever been on a therapeutic diet, e.g., low cholesterol, weight reduction?
  Yes ___ No ___ If Yes, what? _____
- Have you or your child ever had diet counseling? Yes ___ No ___
- Do you or your child play/exercise regularly? Yes ___ No ___ Sometimes ___

I, the undersigned, hereby attest that the above information is true/accurate. I authorize the Nutrition Exchange staff to disclose the information as needed to my physician, other health care professionals and my insurance company. Insurance payment is authorized to the provider. It is authorized for the periods indicated below. You will receive a phone message on appointment date/time.

Clients will be charged $25 for an appointment unless 24 hours notice is given for cancellation. I have received a copy of the HIPAA Notice of Privacy Rights. This release is valid only until _____.

_____ _____

Client/Client's Guardian Date