NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

108 E Poinsett Street
Greer, SC 29651

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly or indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name ____

Relationship to Patient ____

Signature ____

Date ______________________________

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement of this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date __________ Initials _________ Reason _____________________________

Client Information Sheet

Please help us serve you better by taking a few minutes to provide the following information:

Client Name: ____ D.O.B.______________ Age: __________

Gender: ☐ M ☐ F Preferred Ph# ____

Email ________________________________ Preferred method of contact ______________________

Employer Name/Type of Work ____

Marital Status: ☐ Married ☐ Single ☐ Separated ☐ Divorced Number of children: ________

Medical History

Height: _______ Current Weight: _______ Weight 1 year ago: __________ Desired Weight: _________

Have you recently lost/gained weight in the last ________ months? ☐ Yes ☐ No Amount: _________

Was this an intentional change? ☐ Yes ☐ No

Do you weigh yourself? ☐ Yes ☐ No

Are you concerned with your weight? ☐ Yes ☐ No

Are you currently taking any vitamins, Minerals or Herbal supplements? ☐ Yes ☐ No

If Yes, Specify: ____

____

____

Lifestyle

Please list your current stresses: ____

____

____

What are your hobbies or interest? ____

____

____

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Please indicate whether you or a family member have/had any of the following conditions:

	Patient	**Family History**	**Relationship**	**Treatment**
Heart Attack	_______	______________	_____________	__________
Cardiovascular Disease	_______	______________	_____________	__________
Stroke	_______	______________	_____________	__________
Diabetes	_______	______________	_____________	__________
High Blood Pressure	_______	______________	_____________	__________
Kidney Disease	_______	______________	_____________	__________
Cancer (type)	_______	______________	_____________	__________
Thyroid Disease	_______	______________	_____________	__________
High Cholesterol	_______	______________	_____________	__________
Arthritis	_______	______________	_____________	__________
Osteoporosis	_______	______________	_____________	__________
Obesity	_______	______________	_____________	__________
Intestinal Problems	_______	______________	_____________	__________
Food Allergies	_______	______________	_____________	__________
Food Intolerances	_______	______________	_____________	__________
Mental Health Issues	_______	______________	_____________	__________
Other: ________________	_______	______________	_____________	__________

Are you currently being treated for any medical conditions?

____

____

____

List any medications you are currently taking or have taken in the last year:

____

____

____

Allergies to Medications: ____

List All Prior Surgeries:

______________________________________ ______________________________________

______________________________________ ______________________________________

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Eating Habits:

Do you routinely skip meals? ☐ Yes ☐ No If Yes, explain ____

____

How many days/week do you eat? Breakfast: ______ Lunch: ______ Dinner: ______ Snacks: ______

When do you usually snack? ____

What do you choose typically as a snack? ____

Do you buy or pack your lunch? ☐ Buy # of days/week: ________ ☐ Pack # days/week _________

Do you eat out? ☐ Yes ☐ No How Often? ____

Do you order take out? ☐ Yes ☐ No How Often? ____

Do you eat fast food? ☐ Yes ☐ No How Often? ____

List restaurants you usually choose: ____

____

Who does the grocery shopping? ____

Who prepares/cooks the meals? ____

Do you read food labels? ☐ Yes ☐ No

What are your favorite foods? ____

____

____

What foods do you dislike? ____

____

____

What are your goals? Please list and prioritize with #1 as most important.

____

____

____

____

____

____

____

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____

____

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Social History

Do you smoke? ☐ Yes ☐ No Amount/Day: ___________ How long have you smoked? _______

If you quit smoking, when? ______________

Do you use alcohol? ☐ Yes ☐ No Number of drinks/week: _________

Do you use caffeine? ☐ Yes ☐ No How often/week: ___________________________

Weight History (complete if applicable):

How many times have you tried to lose weight? _________ What did you do? ____________________________

Why did you go on a diet? ____

Have you ever used any of the following for weight control?

Commercial Diet Programs ☐ Yes ☐ No ____

Liquid Diets ☐ Yes ☐ No ____

Fad Diets ☐ Yes ☐ No ____

Prescription Diet Pills ☐ Yes ☐ No ____

Over-the-counter diet pills ☐ Yes ☐ No ____

Have you ever been diagnosed with an eating disorder? ☐ Yes ☐ No

Please explain: ____

____

Exercise History:

Is there any reason why you cannot or should not exercise? ☐ Yes ☐ No

If yes, please list reasons: ____

____

Are you currently exercising? ☐ Yes ☐ No

Please list type, duration, frequency and intensity of exercise activities.

____

____

How much time per day could you devote to exercise? ____

For incorporation of physical activity, of the 3 options, please select which is most sustainable to apply to your lifestyle?

☐ Lightly active – 30 minutes of moderate activity (like walking), 0 minutes of vigorous activity (like jogging) and 5000 steps/day
☐ Moderately active – 30 minutes of moderate activity, 15 minutes of vigorous activity and 8000 steps/day
☐ Very active – 60 minutes of moderate activity, 30 minutes of vigorous activity and 10,000 steps/day
☐ Extremely active – 90 minutes of moderate activity, 60 minutes of vigorous activity and 15,000 steps/day

**A good rule of thumb:*
During moderate activity you can easily talk during the activity. During vigorous activity you cannot get out more than a few words without having to catch your breath.

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What kinds of fat do you use for frying and sautéing at home?

☐ Butter ☐ Margarine ☐Olive Oil ☐Other Oil: ____

☐ Cooking Spray ☐ Shortening or Lard

What kind of spread do you use on bread?

☐ Butter ☐ Regular Margarine ☐ Low Calorie Margarine ☐ Other: _____________________________________

Please list the foods and drinks that you have consumed in the past 24 hours.

	Time & Place	**What did you eat & drink? (Include amount)**
BREAKFAST		
SNACK		
LUNCH		
SNACK		
DINNER		
SNACK		
OTHER		

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Circle the vegetables that you eat. Note the number of servings from each group that you eat daily, weekly or monthly.

	Servings/Day	Servings/Week	Servings/Month
Non-starchy Vegetables Asparagus, beets, broccoli, Brussel sprouts, cabbage, carrots, cauliflower, celery, cucumber, eggplant, green beans, mushrooms, okra, onions, peppers, summer squash (yellow or zucchini), tomatoes, turnips, wax beans			
Leafy Vegetables Salad greens, kale, mustard greens, spinach, sprouts, turnip greens, watercress			
Starchy Vegetables Corn, dried beans or peas (pinto, kidney, white, black, brown beans, lentils, split peas, black-eyed peas, etc.), green peas, lima beans, potatoes, sweet potatoes, winter squash (acorn, butternut), yams, mixed vegetables with corn, peas, or pasta.			

Circle the fruits that you eat. Note the number of servings from each group that you eat daily, weekly or monthly.

	Servings/Day	Servings/Week	Servings/Month
Fresh Fruit Apple, apricot, banana, blackberries/blueberries/other berries, cantaloupe, cherries, grapefruit, grapes, honeydew, kiwi, mango, nectarine, orange, papaya, peach, pear, pineapple, plum, strawberries, tangerine, watermelon, other			
Canned Fruit **(including fruit cups)** Applesauce, apricot, fruit cocktail, grapefruit sections, mandarin oranges, peaches, pears, pineapple, other			
Dried Fruit Apple, apricot, cranberries, craisins, dates, figs, peaches, prunes, raisins, other			
Juice Apple, cranberry, grape, grapefruit, mixed fruit, orange, pineapple, prunes, other			

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Other Foods: Use the chart to note how often you eat each type of food.

	Servings/Month		Servings/Week			Servings/Day			
	0	1-4	1	2-4	5-6	1	2-3	4-5	6 or more
Milk									
Cottage or Ricotta cheese									
Processed cheese (American)									
Natural hard cheeses (cheddar, Colby, etc.)									
Yogurt									
Frozen yogurt									
Ice Cream									
Other frozen desserts									
Soup									
Casseroles									
Salami, bologna, other lunch meat									
Deli ham, deli turkey and other deli meats									
Ground beef									
Steak									
Other beef as main dish									
Baked ham									
Pork chop or other pork as main dish									
Sausage									
Bacon									
Baked, broiled or stewed chicken									
Fried Chicken									
Turkey or other poultry									
Shrimp, lobster or scallops									
Salmon, mackerel or tuna									
Other fish, not fried									
Cold breakfast cereal									
Cooked breakfast cereal									
Bread, regular									
Bread, diet or low-calorie									
Bagel or English muffins									
Pancakes and waffles									
Danish, doughnuts, pastry									
Flour tortillas									
Corn tortillas									
Rice									
Crackers									
Pasta (i.e. spaghetti)									
French fries									
Potatoes (other than French fries)									

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	Servings/Month		Servings/Week			Servings/Day			
	0	1-4	1	2-4	5-6	1	2-3	4-5	6 or more
Pizza									
Chips (potato, corn, etc.)									
Pretzels									
Popcorn									
Peanut Butter									
Peanuts									
Other nuts (any kind)									
Chocolate									
Other Candy									
Cake									
Pie									
Cookies									
Brownies									
Sugar (added to tea, coffee, cereal, etc.)									
Sweetened Tea									
Unsweetened Tea									
Honey, Jam or Jelly									
Pancake syrup									
Punch or lemonade									
Soda, regular (12 oz.)									
Soda, diet (12 oz.)									
Beer, regular (12 oz.)									
Beer, light (12 oz.)									
Wine (4 oz.)									
Hard liquor (1 shot)									
Mixed drinks/cocktails									
Margarine									
Butter									
Salad Dressing (any type)									
Mayonnaise									
Other Foods (list):									

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On a scale from 1-10, how important is it to you to make the necessary changes to meet your goals?
(10 – extremely important; 1 – not important at all)

10 9 8 7 6 5 4 3 2 1

On a scale from 1-10, how confident are you that you can make the necessary changes to meet your goals?
(10 – extremely important; 1 – not important at all)

10 9 8 7 6 5 4 3 2 1

Circle where you fall on the scale – How ready are you to make the necessary changes to progress towards our personal goals?
(10 – extremely important; 1 – not important at all)

10 9 8 7 6 5 4 3 2 1

Please describe your goals in order of priority: ____

____

____

____

____

Please select the area in which you would desire more information and instruction:

☐ Portion Control
☐ Meal Patterns
☐ Reading Food Labels
☐ The Exchange List
☐ Healthy Tips for Dining Out
☐ Mindful Eating
☐ Meal Planning
☐ Balanced Eating within Food Groups
☐ Food Journaling
☐ Sodium
☐ Other ___________________________________
☐ Other ___________________________________

____ _________________________

Client Signature ***Date***

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Office Policy Information

Confidentiality: All information disclosed within sessions is confidential as outlined in the HIPAA Notice of Privacy Practices.

Payment For Service: The fee is $____________ for a __________ minute appointment, payable via check or cash. You are requested to pay for services each session unless other arrangements are made. Please make checks payable to Upstate Nutrition Consultants. You will be provided with an invoice that you can submit to your insurance company for possible reimbursement – please check with your insurance company to verify if your benefits include medical nutrition therapy. Each check returned by the bank will be assessed $20.00 service fee. *If any problem arises during the course of treatment regarding your ability to pay, please be sure to discuss this so that we can consider alternative arrangements that may allow you to continue with treatment.*

Cancellation: A minimum of 24-hours notice is required to reschedule or cancel an appointment. The full fee will be charged for missed sessions without such notification. Thank you for your cooperation. If you would like a reminder phone call or email prior to you appointments, please inform us.

Consent for Treatment: In signing this contract you are consenting for treatment with ________________________________ for medical nutrition therapy. Please ask any questions you need to have answered in order to understand before signing.

Waiver of Liability: On behalf of myself and/or my minor son/daughter _________________________, I hereby release Upstate Nutrition Consultants and its officers, agents, employees, and assigns from any and all liability arising out of or in any way related to the afore-mentioned medical nutrition therapy treatment provided by Upstate Nutrition Consultants.

By signing this form, I acknowledge that I have read and understand the above information. I hereby consent to evaluation for treatment under the terms specified above.

Today's date: __________________________ Name of Child, if applicable: ______________________

Your signature: ____

Printed name: ____

Address: ____

City: ____ State: __________ Zip: ________________________

Phone: ____ Alternate Phone: ________________________________

❒ Please give me a reminder phone call or email prior to my appointments. It is ok to leave a message on my answering machine/voice mail.
Email:____ Phone: ___________________________________