NUTRITION INTAKE FORM

Nourish
Custom Nutrition

FIRST & LAST NAME (PLEASE PRINT) TODAY'S DATE

STREET ADDRESS CITY STATE ZIP CODE

PHONE EMAIL DATE OF BIRTH

EMERGENCY CONTACT PCP

CURRENT WEIGHT _____

ARE YOU A SMOKER? _____ ALCOHOLIC DRINKS YOU CONSUME PER WEEK _____

HEALTH HISTORY

WHAT ARE YOUR CURRENT HEALTH PROBLEMS FOR WHICH YOU ARE SEEKING TREATMENT?

WHAT OTHER FORMS OF TREATMENT HAVE YOU SOUGHT?

CIRCLE THE LEVEL OF STRESS YOU ARE EXPERIENCING FROM 1 TO 10 (1 BEING THE LOWEST)

1 2 3 4 5 6 7 8 9 10

CURRENT MEDICATIONS/ SUPPLEMENTS

PLEASE LIST ANY MAJOR HOSPITALIZATIONS, SURGERIES, INJURIES OR LAB PROCEDURES

WHAT ARE YOU HEALTH GOALS?

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NOTICE OF PRIVACY

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment or practice operations will be made only after obtaining your consent.

- You may request restrictions on your disclosures.
- You may inspect and receive copies of your records within 30 days with a request.
- You may request to view changes to your records
- In the future, we may contact you for appointment reminders, announcements and to inform you about our practice and its staff.

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 with multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third party payers
- Conduct normal healthcare operations such as quality assessments and physician's certifications.

I have read and understand your Notice of Privacy Practices. A more complete description can be requested. I also understand that I can request, in writing, that you restrict how my personal information is used and or disclosed.

NAME OF INDIVIDUAL YOU ARE GRANTING PERMISSION

RELATIONSHIP TO PATIENT & PHONE NUMBER

PATIENT NAME (PLEASE PRINT)

PATIENT SIGNATURE