Patient Intake Form

Today's Date (MM/DD/YYYY): _____

First Name: _____

Middle Name (or Initial) _____

Last Name:_____

Birth date: _____/_____/_____ Age: _____

Marital Status: Single / Married / Other: _____

Gender: _____ Ethnicity : _____

Address:_____

City: _____ State: _____ Zip: _____

Home #: (_____)_____ Work: (_____)_____

Cell: (_____)_____

Email Address:_____

Preferred Contact Method: _____

Occupation: _____

Emergency Contact: _____

Emergency Contact's Phone: _____

How did you find us? : _____

Have you seen a nutritionist before? If so who? _____

Dietary Intake

Are there foods you crave? _____

Are there foods you avoid? _____

Do you have any allergies or intolerances to food? _____

Current Illnesses: _____

_____

Medications/ Supplements: _____

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

Please describe: _____

Do you have concerns about your relationship with food? Yes No

Please describe: _____

_____

Primary complaint: _____

_____

Check all that apply:

Rushed at meals
Eat excessively if bored or emotional
Sneak or hide food
Feel out of control around food
Eat at my desk
Eat in front of the TV
Get sick after eating
Feel stuffed after meals
Skip meals frequently
Feel satisfied after eating

For each statement below indicate the frequency: Daily, 3-5 per week, 1-2 per week, 1-2 per month, Less than monthly, Never

Cook meals at home _____
Eat with others _____
Eat at restaurants _____
Eat at fast food restaurants _____
Eat Pastries, cookies, candies, ice cream, other sweets _____
Add sugar to coffee, tea, cereals or other foods _____
White bread or white products _____
Sodas or other soft drinks _____
Artificial sweeteners (Saccharin, Nutrasweet, Splenda...) _____
Canned foods _____
Cold breakfast cereals list brands _____
Caffeine drinks (coffee, tea, cola, chocolate) _____
Deep fried foods _____
Margarine of any type _____
Red meat _____
Processed meat (bologna, bacon, sausage,salami)_____
Chicken or turkey _____
Fish _____
Shellfish _____
Milk _____
Cheese _____
Yogurt _____
Eggs _____
Nuts and seeds _____
Whole grains _____
Fruit _____
Vegetables _____
Green leafy vegetables _____
Beans and legumes (lentils / kidney / chickpea) _____
Herbs, and spices, fresh dried _____
Drink adequate water (Tap / Filtered / Bottled)_____
Alcohol _____
Smoking _____
Buy organic foods and produce _____
Appetite Suppressants and Laxatives _____
Antacids _____

Cassie Greenwade Financial Agreement and Office Policies

Rates:
Nutrition Therapy Rates:
cash/check/credit payment at the time of service
Initial consult fee (60 minutes) $100
Follow up visits (30 minutes) $50

Packages:
cash/check/credit card payment at the time of service
The Healthy Reset (6 weeks) $480
Healthy Reboot Pantry Cleaning (60 minutes) $80
Grocery Tour (60 minutes) $80
Meal Planning/ meal creation ……...$80

Financial Agreement

> Payment for visit is to be rendered at time of service and can be made by cash, check, or credit card. Checks are to be made payable to Real Nutrition Now. There is a $35 NSF fee on all returned checks.

Cancellation Policy

> No charge for any cancellations greater than 24 hours. A $45 fee will be charged for no-shows or cancellations within 24 hours.
>
> I, _____ agree to the above defined financial and cancellation policies for Cassie Greenwade. In the case of default of payment, I am responsible for full payment of the balance, interest accrued, and any collection costs and legal fees incurred to collect on this account. I, the undersigned, have read, understand, and accept the information and conditions specified in this agreement.
>
> _____ Signature _____ Date