

Nutrition For Life

Jackie Griffiths, MBA, LRD

NUTRITION REGISTRATION INFORMATION *(Please Print)*

Last Name _____ First Name _____ Middle Initial _____

STREETADDRESS _____ City _____ ST _____ Zip _____

MAILING ADDRESS _____ City _____ ST _____ Zip _____

E-MAIL ADDRESS _____

PHONE (H) _____ (W) _____ (C) _____

BIRTHDATE _____ AGE _____ Sex _____ Marital Status _____

PRIMARY PHYSICIAN _____

Referred By _____

Your EMPLOYER _____

Your OCCUPATION _____

PRIVACY CONSENT

Nutrition For Life requires your consent to use and disclose your protected health information to carry out treatment, payment and healthcare operations. If you would like a more detailed description of such uses and disclosures please refer to our Notice of Privacy Practices. You have the right to review our Notice of Privacy Practices before signing this Consent. The terms of our Notice of Privacy Practices of Nutrition For Life may change from time to time. You can get a copy of our revised Notice of Privacy Practices by contacting Nutrition For Life at 701-293-0002. We will also post a copy of our current Notice of Privacy Practices in our office. You have the right to revoke this consent in writing and the revocation will be effective except to the extent Nutrition For Life has acted in reliance on your consent.

I have had an opportunity to discuss with the Registered Dietitian and/or with other office personnel, the nature and purpose of medical nutrition therapy. I understand the results are not guaranteed. I give Nutrition For Life permission to send a summary note to my physician or referring doctor of my consultation here if required by your physician.

By signing below, you hereby consent to our use of your protected health information for treatment, payment and health care operations and acknowledge receipt of a copy of this Consent if requested.

Printed Name: _____

Signature: _____ **Date:** _____

Nutrition Assessment

Reason for today's visit: _____

1. Personal goals you hope to achieve as a result of nutrition counseling?

2. List any medications that you are currently taking and their uses:

3. List any herbal and/or vitamin/mineral supplements you are taking:

4. Are you currently engaged in a regular exercise program? Yes ____ No ____

Please describe:

5. Are you experiencing any of the following (circle any or all that apply):

nausea vomiting chronic diarrhea chronic constipation Other: _____

6. What was your highest adult weight? _____

7. What was your lowest adult weight? _____

8. What is your height? _____

9. Past medical history that we should be aware of:

10. Do you smoke cigarettes? _____

11. List your hobbies, television habits, and reading habits

12. Please add any other comments that you would like us to know:
