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The Nutrition Experts

PCOS INITIAL SCREENING & REGISTRATION

(Please print clearly)

Patient Name: First Middle Last			Home Phone Number:	
Home Address: Apt. No.	City:		State	Zip Code:
Occupation:	Marital Status	Date of Birth	Age:	Gender:
E-mail address:	Cell Phone:			
Employer:	Address:	Work Phone Number:		
Spouse (or parent) name:				
Spouse (or parent) employer:		Work Phone Number:		
Family Physician:	Address:	Phone:		
Referred By:	Address:	Phone:		
Therapist:	Address:	Phone:		
Psychiatrist:	Address:	Phone:		

POLICIES

Privacy:
Rebecca Bitzer MS RD & Associates (RBA) 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 RBA may change from time to time. You can get a copy of our revised Notice of Privacy Practices by contacting our office at 301-474-2499. 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 RBA 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 RBA permission to send a summary note to my physician or referring doctor of my consultation here.

Policies to Know:
- We require 24 hour notice to cancel and/or change follow-up appointments, or you may be charged up to the full appointment fee.
- There is a $25 fee for any returned checks. All payments for a returned check and further payments will be do in cash or money order only.

Thank you for your cooperation!

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. I have also read and understand these policies.

Printed Name: _____

Signature: _____ **Date:** _____

Patient Name: _____ Date: _____

Health History	
List Your Main Health Concerns (In order of importance)	Duration of Problem
1.	
2.	
3.	
4.	

Please list all surgeries		
1.	2.	3.

Circle (Or Write In) All Medical Conditions Previously Diagnosed			
Arthritis, Rheumatoid	Thyroid Problems	Hypoglycemia	High Blood Pressure
Arthritis, Osteo	Depression/Anxiety	Ovarian Cysts	High Cholesterol
Asthma	Diabetes	Irritable Bowel Syndrome	Food Allergies:
Attention Deficit Disorder	Eczema	Lactose Intolerance	Bipolar/Schizophrenia
Celiac Disease	Gastroesophageal Reflux	Migraines	Vitamin/Nutrient Deficiencies
Chronic Fatigue Syndrome	Sleep Apnea	Infertility	Other:
Hives	Epilepsy	Ulcerative Colitis	Other:

List All Medications And Supplement You Currently Take Regularly OR As Needed (Prescription & OTC)			
Drug	Dosage	# Times Per Day	Start Date

List any family medical history that we should be aware of:
Is there any other medical information concerning you that we should be aware of:

PCOS Nutrition Assessment

Patient Name: _____	Ht: _____
Date: _____	Wt: _____

Please provide the following information on professionals with whom you are in treatment.			
	Physician	Specialist	Therapist
Name			
How often do you meet?			
How long have you seen?			

What brings you here today?
Do you want to be here?
Have you seen a Registered Dietitian or Nutritionist in the past? What did you like/dislike about the visits?
If you could wave a realistic wand, where would you like your health to be in the next 3 months, 6 months, year?
What do you think could be slowing you down, standing in your way or stopping you from meeting these goals?

Self-Assessment (Scale: excellent, good, fair, poor)
1. How do you rate your eating habits? Why?
2. How do you rate your current weight? Why?
3. How do you rate your fitness level? Why?
4. How do you rate your overall health? Why?
5. List one thing pertaining to your eating habits that you're proud of.

History

Following are questions relating to your eating, exercise patterns, weight history, and family history. Please complete them to the best of your ability.

1. What was your favorite food at:
   a. Age 8
   b. Age 10
   c. Age 15
2. Describe what hunger feels like to you:
3. Describe what fullness feels like to you:
4. How do you know when to stop eating?
5. Do you usually eat when you get hungry? (Yes/No) Describe:
6. Do you often eat when you are not hungry? (Yes/No) Describe:
7. Can you tell the difference between physical hunger and "emotional hunger?
8. What do you do if you think you've eaten too much?
9. What was your highest weight? Age?
10. What was your lowest weight? Age?
11. How often do you weigh yourself?
12. What is your desired weight? Last time you weighed this? For how long?
13. What do you believe is a reasonable weight for optimal health?
14. "Set point: is a weight where the body tends to stabilize and eating patterns become easier to normalize."
    What do you think your set point is? Last time you weighed this? For how long?
15. What was your perception of life at highest weight (friends, grades, career, family life, etc.)
16. When was your first diet? What was it?
17. Circle any of the following that describes your eating patterns:
    a. Eat 3 meals each day.
    b. Eat a 'normal' amount of food.
    c. Eat 3 meals with snacks.
    d. Eat 1 or 2 meals each day.
    e. Often overeat at meals/snacks.
    f. Drink fluids throughout the day.
    g. Drink fluids occasionally.
    h. Eat out at least once each day.
    i. Eat small amounts throughout the day.
    j. "Graze" constantly.
18. Are you currently engaged in a regular exercise program? If so, please describe.
19. Describe past history with exercise.

20. Do you consider yourself a compulsive exerciser? (Yes/No)

21. List any goals you hope to achieve in the following areas as a result of nutrition counseling.
    a. Nutrition
    b. Eating pattern
    c. Exercise
    d. Other

22. 24 Hour Dietary Recall

"GOOD DAY"

Breakfast	Snack	Lunch	Snack	Dinner	Snack

"BAD DAY"

Breakfast	Snack	Lunch	Snack	Dinner	Snack

23. Please list one of your favorite types of meals to order when dining out.

24. How does it feel to talk about your food?

25. Do you like to cook? How would you describe your cooking style?

26. How much of each do you consume each day:

Fluid _____	Caffeine _____	Alcohol _____
Smoke _____	Gum _____	Drugs _____

27. Food Allergies:

28. Food Intolerances:

29. What nutritional supplements, vitamins, or herbs are you taking?

30. Social Eating Patterns: who do you generally eat with?

31. Begin with the first time you were concerned with your weight, shape, and/or eating and share with me what happened with your eating and weight until the present time.

32. Rituals

a. BEFORE: What do you do right before you eat (wash hands, drink water, other)?

b. DURING:

i. How long does it take to eat a meal?

ii. How do you choose what you will eat first?

iii. How many bites does it take to eat a food?

c. AFTER: What do you do within 30 minutes of eating?

33. Profession: Place of Employment:

34. If in school, name of school: Grade:

35. Single/Married

36. Are you on birth control pills?

37. Approximate date of last menstrual period?

38. What is your average weight fluctuation during your cycle?

39. How old were you when you first started your menstrual cycle? What was your weight?

40. As you lose weight do your cycles become irregular or cease? (Yes/No) If yes, what was weight?

41. Number of Pregnancies_____ Miscarriages_____ Live Births_____

42. Are you hoping to become pregnant sometime in the next 2-5 years?

43. Children/Siblings (Names/Ages)

44. Current living situation (single apartment, roommate, home with parents, home with other relative)

45. Are parents divorced? Age of client at time of divorce.

46. What do people close to you think about your eating and weight?

47. Describe the food/nutrition habits and body size of the following people:
    a. Mom
    b. Dad
    c. Sibling 1
    d. Sibling 2
    e. Sibling 3
    f. Spouse
    g. Grandparents
48. Any members of family eating disordered?
49. Any members of family alcohol abusers?
50. What are your hobbies and interests?
51. What are your television/computer, sleeping, and reading habits? (What time of day? How many hours per day, on average?)
    a. Television
    b. Computer
    c. Reading
    d. Sleep
52. Please add any additional comments that you would like me to know: