Welcome to Nutrition at CHI Health Care!

For your appointment, please complete the following 3 forms:

- Medical Nutrition Therapy Consent Form
- Medical Nutrition Therapy Health Questionnaire Form
- Medical Nutrition Referring Provider Form

Please note that the Referring Provider form must be completed by your primary care or your referring physician. Please submit the form to them and ask them to fax it back to us or you may return it to us by your first appointment. Please note that if we do not have this form when you arrive for your first appointment, you will be rescheduled.

There are instructions on each form. There is no judgment in this process so please be as honest and complete as possible. Please return all forms to CHI via fax (301-963-0072) or in person **in advance** of your appointment. We ask that you try to return them at least 2 business days prior to your appointment. Thank you and I look forward to helping you with your journey to nutritional wellness.

Warmly,
Xonna Clark, MS, LDN, CNS
Clinical/Functional Nutritionist

Patient Name:	Date:

Medical Nutrition Therapy Health Questionnaire

Please complete this form and return it prior to your first visit.

Please list and prioritize your nutrition concerns (1=most important)		How long? Have you sought treatment?
1.		☐ yes ☐ no
2.		☐ yes ☐ no
3.		☐ yes ☐ no

Please list the current medications/supplements you are taking:

Name	Brand	Dosage	Frequency	Date Started	Purpose

List the major events of your health history. Examples are significant illnesses, surgeries, accidents, toxin exposure, heavy metal exposure, antibiotics (in large doses or for long periods of time).

_____
_____
_____
_____
_____
_____

What do you believe you can do to make a difference in your current health?

_____
_____

CHI HEALTH CARE

_____

_____

Personality – Do you consider yourself? ☐ Type A ☐ Free Spirit ☐ A Blend of both
Do you like to make changes all at once ☐ or ☐ Implement change slowly over time
Do you feel supported when you make changes to your diet? ☐ Yes ☐ No ☐ Sometimes
Do you more often feel: ☐ Hot ☐ Cold ☐ Cerebral ☐ Emotional ☐ Introvert ☐ Extrovert

Physical Activity:

Do you enjoy exercise?: ☐ Yes ☐ No
What forms of exercise do you do on a weekly basis?

_____

_____

Symptom Questionnaire: Please write **yes** or **no** after each question.

Section 1:

	Yes/No
Indigestion, burping, bloating or sleepy immediately after meals	
Heartburn or acid reflux symptoms	
Tendency to allergies, eczema, asthma	
Nausea in evenings	
Proteins hard to digest, complex meals hard to digest (combination of proteins and carbs)	
Loss of taste for meat	
Sense of excess fullness after meals	
Feel like skipping breakfast, overall low appetite	
Undigested food in stool	
Anemia, unresponsive to iron	

Section 2:

	Yes/No
Heartburn or acid reflux symptoms	
Nausea in mornings	
Strong appetite, demanding hunger, excess salivation	
Aggravated by spice or sour, sour burps, sour smell	

Section 3:

	Yes/No
Pain between shoulder blades	
Stomach upset by fatty or fried foods	
Loose stools with fatty foods, irregular stools, fat in stools (shiny, floating), smelly stools	
Nausea	
Light, clay colored or greenish/yellow stools	
Dry skin, itchy feet or skin peels on feet	
Gallbladder attacks	
Gallbladder removed	
Pain under right side of rib cage	

Easily intoxicated or hung if you were to drink wine	
Hemorrhoids or varicose veins	
Sensitive to chemicals (perfume, cleaning agents, etc.), diesel fumes or tobacco smoke	

Section 4:

	Yes/No
Food allergies or sensitivities (wheat or grain, or dairy or other)	
Frequent intake of allergenic food(s), strong attachment to allergenic foods	
Craving, addiction or binging of allergenic food(s)	
Abdominal bloating 1-2 hours after eating	
Pulse speeds up after eating	
Crohn's disease, frequent sinus infection, migraines, asthma	
Airborne allergies	
Experience hives	

Section 5:

	Yes/No
Catch colds at the beginning of winter	
Frequent colds, flu or other infections (sinus, ear, bladder, skin, etc.)	
Experienced a mucus-producing cough	
Never get sick	
History of Epstein Bar, Mono, Herpes, Shingles, Chronic Fatigue Syndrome, Hepatitis or other chronic viral conditions	
Have food allergies or sensitivities	

Section 6:

	Yes/No
Coating on your tongue	
Anus itches	
Fungus or yeast infections	
Yeast symptoms increase with sugar, starch or alcohol consumption	
Less than one bowel movement a day	
Constipation, stools hard or difficult to pass	
Excessive foul smelling lower bowel gas	
Irritable bowel or colitis	
Bad breath or strong body odor	
Cramping in lower abdominal region	
Stools are difficult to pass	
History of parasites	
Stools have corners or edges, are flat and ribbon shaped	

Section 7:

	Yes/No
Eat less than five servings of colored vegetables or fruits per day (one-half cup cooked, 1 cup raw)	
Crave sweets, breads, rolls, cookies, pasta, pizza or chips	
Crave coffee or sugar in the afternoon	

Sleepy in the afternoon	
Fatigue is relieved by eating	
Bingeing or uncontrolled eating	
Excessive appetite	
When you eat snacks/sweets, do you eat them, get a temporary boost of energy or mood, then crash	
Headache, irritability or shakiness if meals are skipped or delayed	
Heart palpitations after eating sweets	
Have frequent thirst	
Have frequent urination	
Once you start eating sweets or carbohydrates, do you feel you can't stop	
Tend to gain weight in the belly	
Have pre-diabetes, diabetes, PCOS, hypoglycemia or alcoholism, or a family history of any of these	
Have elevated triglycerides or cholesterol	
Have high blood pressure	

Section 8:

	Yes/No
Have high or low blood pressure	
Have a low libido	
Have trouble falling asleep	
Get less than 8 hours of sleep per night	
Go to bed frequently after midnight	
Get less than 1 hour per day of sunlight	
Work the night shift	
Are you an emotional eater	
Feel anxious or have panic attacks	
Are you a shallow breather	
Experience heart palpitations	
Cravings for salt or sweets	
Experience chronic or prolonged fatigue	
Does fatigue prevent you from doing things you would like to do	
Do you feel you can't get started in the morning without coffee or caffeinated drinks	

Section 9:

	Yes/No
Are you cold when everyone else is warm	
Have coarse or brittle hair	
Experience constipation	
Have thinning or hair loss	
Experienced a loss of sex drive	
Lost the outside of your eyebrow	
Experience depression	

Have trouble losing weight	
Have a low blood pressure or heart rate	
Have elevated cholesterol	
Have a hoarse voice	
Have dry, scaly skin	
Have cold hands and feet	
Experience fatigue	
Experience fluid retention	

Section 10:

	Yes/No
Aware of irregular or heavy breathing	
Experienced discomfort at high altitudes	
Sigh frequently or “air hunger”	
Have shortness of breath with moderate exertion	
Experience swelling of the ankles, especially at end of day	
Blush or face turns red for no reason	
Experience a dull pain or tightness in chest and/or radiates into left arm, worse on exertion	
Have muscle cramps on exertion	

Section 11:

	Yes/No
Rarely break out into a sweat	
Use aluminum cooking equipment	
Have mercury amalgams	
Yeast symptoms increase with sugar, starch or alcohol consumption	
Less than one bowel movement a day	
Constipation, stools hard or difficult to pass	
Excessive foul smelling lower bowel gas	
Irritable bowel or colitis	
Bad breath or strong body odor	
Cramping in lower abdominal region	
Stools are difficult to pass	
History of parasites	
Stools have corners or edges, are flat and ribbon shaped	

Dietary Intake:

Have you ever had a nutritional consult? ☐ Yes ☐ No If so when:

List any structured or popular diets that you are following, have tried, or completed in the past:

Name	When	Duration	Did you enjoy it?	Successful
			☐ Yes ☐ No	☐ Yes ☐ No
			☐ Yes ☐ No	☐ Yes ☐ No
			☐ Yes ☐ No	☐ Yes ☐ No

Have you ever had a food allergy/sensitivity test?
☐ Yes ☐ No Name & Date of Test: _____

Food Allergies/Sensitivities

	Typical Reaction	*Severity 1-10 (10=severe)*
Please list food allergies:		
Please list food sensitivities:		
Non-food & Environmental allergies:		

Where do you primarily grocery shop?
_____

What percentage of your groceries are: Organic_____% Packaged or Pre-Prepared_____ %

Please describe your relationship to food:

_____

Where do you eat most of your meals? (table, sofa, standing, car, alone, etc.)

_____

Do you frequently eat fast or on the run? ☐ Yes ☐ No

Chewing speed 1-10: (10=very fast) _____

Do you like to cook? ☐ Yes ☐ No

How many meals per week are home-cooked? _____ How many meals per week are eaten out? _____

On a scale of 1-10, (10=nourishing and healthy) rate your current diet and eating habits: _____

How willing are you to make changes? 1-10 (10=very willing) _____

Please feel free to provide any additional information in the space below:

_____

_____

_____

_____

MEDICAL NUTRITIONAL THERAPY INFORMED CONSENT AND DISCLAIMER

Before you choose to use the services of Medical Nutritional Therapy, please read the following information FULLY AND CAREFULLY.

GOAL: The basic goal is to encourage people to become knowledgeable about and responsible for their own health, and to bring it to a personal optimum level. Medical Nutritional Therapy is designed to improve your optimum health, absent of other non-nutritional complicating factors, and requires a sincere commitment from you, possible lifestyle changes, and a positive attitude. A nutritionist is not trained to provide medical diagnoses, medical codes, or file insurance documentation. No comment or recommendation should be construed as inferring or implying a medical diagnosis. Since every human being is unique, we cannot guarantee any specific result from nutritional programs.

HEALTH CONCERNS: If you suffer from a medical or pathological condition, you need to consult with an appropriate healthcare provider. A nutritionist is not a substitute for your family physician or other appropriate healthcare provider. A nutritionist is not trained nor licensed to diagnose or treat pathological conditions, illnesses, injuries, or disease.

Medical Nutritional Therapy may include a combination of diet and life-style modifications and the use of whole foods and nutritional supplements, such as vitamins, minerals, botanical herbs, amino acids and fatty acids. Nutritional supplements are categorized as food and food products that reportedly provide health benefits.

If you are under the care of another healthcare provider, it is important that you inform your other healthcare providers of your use of nutritional supplements. Medical Nutritional Therapy may be a beneficial adjunct to more traditional care, and it may also alter your need for medication, so it is important you always keep your physician informed of changes in your nutritional program.

If you are using medications of any kind, you are required to alert your nutritionist of such use, as well as to discuss any potential interactions between medications and nutritional products with your pharmacist.

All of the nutritional supplements that we recommend are generally considered safe and non-toxic at recommended doses for most people; however, adverse reactions and unintended side effects can sometimes occur when taking these substances. It is important that you use the nutritional supplements in accordance with the dosage recommended by the nutritionist. It is also important to disclose any previous or current liver or kidney disease or related disease, pregnancy, and any other condition that you believe may have an impact on your health status.

If you have any physical or emotional reaction to nutritional therapy, discontinue use immediately, and contact your nutritionist to ascertain if the reaction is adverse or an indication of the natural course of the body's adjustment to the therapy.

Laboratory testing is done to determine areas of dysfunction, not in diagnosis or treatment. Lab testing can assist in revealing nutritional deficiencies and weaknesses.

COMMUNICATION: Every client is an individual, and it is not possible to determine in advance how your system will react to the supplements you need. It is sometimes necessary to adjust your program as we proceed until your body can begin to properly accept products geared to correct the imbalance. It is your responsibility to do your part by using your nutrition guidelines, exercise your body and mind sufficiently to bring your emotions into a positive balance, eat a proper diet, get plenty of rest, and learn about nutrition. You must stay in contact with your nutritionist so she can let you know what is happening and the best course of action.

You should request your other healthcare providers, if any, to feel free to contact your nutritionist for answers to any questions they may have regarding nutritional therapy.

By my/our signatures below, I/we confirm that I/we have read and fully understand the above disclaimer, are in complete agreement thereto and do freely and without duress sign and consent to all terms contained herein.

NAME: (please print) _____

SIGNATURE: _____

DATE: _____

Referring Provider Form

Front Desk Use Only
Patient Name: _____
Date: _____

Primary Care/ Referring Provider Name: _____

Primary Care/ Referring Provider Address: _____
_____
_____

Primary Care/ Referring Provider Phone Number: _____ Fax: _____

Primary Care/ Referring Provider NPI#: _____

Please list below **ALL** the medical diagnoses for this patient. Nutrition therapy typically covers multiple medical conditions.

DX: _____ Code: _____ DX: _____ Code: _____
DX: _____ Code: _____ DX: _____ Code: _____
DX: _____ Code: _____ DX: _____ Code: _____

Primary Care/ Referring Provider Signature: _____Date: _____

This form is to be completed by your primary care provider's office before your Nutrition Visit.
Please have this form submitted to our office before or on the day of your visit.
If this form is **not completed** your visit will be **rescheduled** until all documents have been submitted.