

## Welcome to a Healthy New Beginning!

Below you will find the 1) overview of services, 2) consent for care, 3) cancellation policy and 4) payment information.

### 1) Overview of Services

Wellness Consultations: 60 minute initial session (\$150), 45 minute follow-up sessions (\$125)

Consultations for optimal health, wellness, energy, and longevity. People to consider this service may include: overweight individuals, over-worked/stressed business people, athletes, moms, those suffering with digestive or infertility symptoms, or people seeking vitamin/mineral/herbal supplement education.

Medical Nutrition Therapy Counseling: 60 minute initial session (\$150), 45 minute follow-up sessions (\$125)

Counseling for the management or prevention of chronic conditions such as high cholesterol, diabetes, obesity, high blood pressure, and cancer.

Couples Nutrition Counseling: 75 minute initial session (\$175), 60 minute follow-up sessions (\$150)

Jump Start Series: 4 sessions (\$450)

Designed for the person interested in information beyond a basic plan. Sessions provide detailed and personalized feedback and strategies for specific obstacles and barriers.

12 Week Weight Management Program: 7 office appointments and 5 e-mail check-ins (\$875)

Learn weight management principles and how to apply those concepts to your individual lifestyle and environment. Learn how to make your social, home, and office environments work for you instead of against you. Designed for the person who wants the most accountability and structure.

The Ultimate 7-Day Diet Plan: plan mailed to you (\$50), plan with 60 minute personalized instruction session (\$150)

This perfectly balanced eating plan is designed to help you lose five pounds in one week. In addition to weight loss, the plan decreases water retention and reduces bloating with the unique combination of foods. You will receive the complete meal plan booklet, detailed grocery list, pictures of each meal and motivational e-mails to keep you going for the week.

Skype Video Nutrition Sessions: 60 minute initial session (\$125), 45 minute follow-up sessions (\$100)

Counseling for individuals who are outside of the Chicago area or interested in personalized counseling from the comfort of their home.

### 2) Consent For Care

I grant permission to *Dawn Jackson Blatner* to perform assessments and recommend treatments as are considered necessary or advised for my diagnosis. I understand that a record will be kept confidential and will not be released to others unless they are involved in my care plan. I understand that I will have the opportunity to ask questions of those involved in my care. I am willfully accepting medical nutrition therapy from *Dawn Jackson Blatner*.

### 3) Cancellation Policy

In order to best serve clients, *Dawn Jackson Blatner* requires 24 hour notification for cancelled appointments. By giving advanced notice, we are able to offer other clients who are waiting for services your appointment slot. Clients who do not cancel appointments within 24 hours will be charged in full for the appointment.

### 4) Payment Information

*Dawn Jackson Blatner* accepts cash, check, or credit card payment at the time of service. You can request a receipt for your payment called a superbill. A superbill is an official receipt of services you can submit to your insurance company. Your insurance company *may* partially or fully cover the registered dietitian services you received and directly reimburse you.

I have read and understand the above information.

\_\_\_\_\_

Date

\_\_\_\_\_

Signature

\_\_\_\_\_

Print Name

Name \_\_\_\_\_

Date \_\_\_\_\_

### BACKGROUND QUESTIONS

Physician name \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

How old are you \_\_\_\_\_ What is your birthdate \_\_\_\_\_

What is your home address \_\_\_\_\_

What is your home phone \_\_\_\_\_ What is your cell phone \_\_\_\_\_

What is your work phone \_\_\_\_\_ E-mail \_\_\_\_\_

What is your occupation \_\_\_\_\_ Normal work hours \_\_\_\_\_

Social Security Number \_\_\_\_\_

Marital Status \_\_\_\_\_

Please list the people in your household and their relationship to you \_\_\_\_\_

\_\_\_\_\_

What is the highest level of education you have attended \_\_\_\_\_

What prompted you to seek dietitian services at this time \_\_\_\_\_

What are your personal goals we can help you achieve \_\_\_\_\_

How ready are you to make lifestyle changes:                      Not ready    1    2    3    4    5    Very ready

### OVERALL HEALTH QUESTIONS

When was your last physical exam \_\_\_\_\_

When did you last have any blood testing \_\_\_\_\_

How do you rate your health:                      \_\_\_\_\_excellent    \_\_\_\_\_good    \_\_\_\_\_fair    \_\_\_\_\_poor

Height \_\_\_\_\_ Weight \_\_\_\_\_

What was your lowest body weight as an adult \_\_\_\_\_ highest \_\_\_\_\_

Do any religious or other practices you have affect your healthcare or diet \_\_\_\_\_

### REVIEW OF SYSTEMS (circle all that apply):

#### Respiratory

Excessive shortness of breath

Coughing

Asthma

Emphysema

Snoring

Daytime sleepiness

Disturbed sleep

Sleep apnea

History of pneumonia, chronic bronchitis

Cardiovascular

Hypertension  
Heart disease/heart attack  
Congestive heart failure  
Heart murmur  
Irregular heart beat

Chest pain  
Ankle or feet swelling  
Varicose veins  
Blood clot

Gastrointestinal

Nausea/vomiting  
Abdominal pain  
Heartburn  
Belching  
Ulcer disease  
Rectal bleeding

Hemorrhoids  
Constipation  
Diarrhea  
Gallbladder disease/stones  
Celiac disease  
Hernia

Genitourinary

Difficulty urinating  
Urinary incontinence  
Inability to empty bladder fully  
Recurrent urinary infections

Infertility  
Sexual problems  
Abnormal menstrual period  
Enlarged prostate

Musculoskeletal

Aching muscles or joints  
Low back pain/vertebral disc problem

Arthritis  
Torn ligaments, muscle soreness

Endocrine

Diabetes Mellitus  
Thyroid disease

Elevated cholesterol or triglycerides  
Gout

Skin

Infection (boils, ulcers, etc.)  
Chronic rashes

Bruises easily  
Excessive hair growth (females)

Other

Low energy level  
Depression, Bipolar, ADD  
Anxiety disorder, OCD, Panic attacks  
Psychological/Psychiatric care  
History of child abuse/rape/molestation

History of any physical violence  
History of cancer  
Anemia  
Sickle cell disease  
Headaches

Initials \_\_\_\_\_

Do you have family history of the following (circle): High Blood Pressure, High Blood Cholesterol, Diabetes, Thyroid Disease, Obesity, Heart Disease, Cancer, Other \_\_\_\_\_

List history of surgeries \_\_\_\_\_

Preventative care screenings and diagnostic tests you have had (circle):

Sigmoidoscopy/Colonoscopy

Mammogram

Cardiac Stress Test

Prostate/Testicular Exam

Bone Density

List current medications and dosages \_\_\_\_\_

Do you have any allergies or intolerances to medications or foods \_\_\_\_\_

How often do you use tobacco \_\_\_\_\_

How often do you drink alcohol \_\_\_\_\_

Average hours of sleep each night \_\_\_\_\_ Is your sleep restful? Yes or No

How would you rate your stress level: low 1 2 3 4 5 high

How do you cope with daily stressors \_\_\_\_\_

## NUTRITION QUESTIONNAIRE

What 1 or 2 things would you like to change about your diet \_\_\_\_\_

What eating habits are you most proud of \_\_\_\_\_

What eating habits need the most improvement \_\_\_\_\_

What is your usual eating pattern (circle):

varies day to day

varies week vs. weekend

grazer

no pattern/random

skip meals

nighttime eating

3 meals/day

3 meals + snacks

Who performs the cooking/shopping \_\_\_\_\_ What grocery store \_\_\_\_\_

Do you read food labels? If yes, what do you look for \_\_\_\_\_

What do you drink with meals and in-between meals \_\_\_\_\_

If you snack, what do you usually snack on \_\_\_\_\_

Out of 7 days, how often do you dine out for breakfast \_\_\_\_\_ lunch \_\_\_\_\_ dinner \_\_\_\_\_

What types of restaurants do you typically frequent \_\_\_\_\_

How often do you eat in front of the TV or computer \_\_\_\_\_

What triggers you to eat (circle): time of day    hunger    seeing/smelling food    emotions    boredom    other

Do you eat more rapidly than others? Yes    or    No

Do you eat until feeling uncomfortably full? Yes    or    No

Do you eat large amounts of food when you are not feeling physically hungry? Yes    or    No

Do you eat alone because of being embarrassed by how much you eat? Yes    or    No

Do you feel disgusted, depressed, or guilty after overeating? Yes    or    No

Do you feel that you cannot control the amounts you are eating? Yes    or    No

Do you have a history of (circle): compulsive over eating,    binge eating disorder,    anorexia,    bulimia,    other

What diets have you tried to lose weight \_\_\_\_\_

What vitamins/supplements do you take \_\_\_\_\_

How confident are you about the **amount** of current nutrition knowledge you have: low    1    2    3    4    5    high

How confident are you about your ability to **apply** the nutrition knowledge you have: low    1    2    3    4    5    high

**PHYSICAL ACTIVITY QUESTIONNAIRE**

What is the most active thing you do in an average day \_\_\_\_\_

What, if any, regular exercise do you participate in and how often:

\_\_\_\_\_

What physical activity would you like to do that you are currently not doing \_\_\_\_\_

If you answer yes to any of the following questions, check with your doctor before starting an exercise program:

Has your doctor ever said that you have a heart condition and that you should only do physical activity recommended by a doctor? Yes    or    No

Do you feel pain in your chest when you do physical activity? Yes    or    No

In the past month, have you had chest pain when you were not doing physical activity? Yes    or    No

Do you lose your balance because of dizziness or do you ever lose consciousness? Yes    or    No

Do you have a bone/joint problem that may worsen by a change in your physical activity? Yes    or    No

Is your doctor currently prescribing drugs for your blood pressure or heart condition? Yes    or    No

Do you know any other reason why you should not do physical activity? Yes    or    No