

## 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: 50 minute initial session (\$225), 40 minute follow-up sessions (\$175)

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: 50 minute initial session (\$225), 40 minute follow-up sessions (\$175)

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 (\$325), 60 minute follow-up sessions (\$250)

Jump Start Series: 4 sessions (\$650)

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 (\$1,350)

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 50 minute personalized instruction session (\$225)

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 and pictures of each meal.

Skype Video Nutrition Sessions: 50 minute initial session (\$225), 40 minute follow-up sessions (\$175)

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

Photo Food Logging: Complete 1-week personalized feedback on food logs (\$125). Technology uses camera phone.

### 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 Information

Physician name: \_\_\_\_\_ Address: \_\_\_\_\_

Phone: \_\_\_\_\_

### Personal Information

Age: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Address: \_\_\_\_\_

Home phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_

Work phone: \_\_\_\_\_ E-mail: \_\_\_\_\_

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

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? (choose #) \_\_\_\_\_ (Not ready 1 2 3 4 5 Very ready)

## OVERALL HEALTH QUESTIONS

Date of your last physical exam: \_\_\_\_\_ Date of last blood testing: \_\_\_\_\_

How do you rate your health? (check one)  excellent  good  fair  poor

Height: \_\_\_\_\_ Current Weight: \_\_\_\_\_

What was your lowest body weight as an adult? \_\_\_\_\_ Highest? \_\_\_\_\_

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

#### Respiratory

- |                                    |                                               |                                       |
|------------------------------------|-----------------------------------------------|---------------------------------------|
| <input type="checkbox"/> Asthma    | <input type="checkbox"/> Sleep apnea          | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> History of pneumonia | _____                                 |
| <input type="checkbox"/> Snoring   | <input type="checkbox"/> Chronic bronchitis   |                                       |

#### Cardiovascular

- |                                                     |                                                   |                                       |
|-----------------------------------------------------|---------------------------------------------------|---------------------------------------|
| <input type="checkbox"/> High blood pressure        | <input type="checkbox"/> Congestive heart failure | <input type="checkbox"/> Blood clot   |
| <input type="checkbox"/> Heart disease/heart attack | <input type="checkbox"/> Ankle or feet swelling   | <input type="checkbox"/> Other: _____ |

CONTINUED (check all that apply):

Initials \_\_\_\_\_

Gastrointestinal

- |                                          |                                                     |                                         |
|------------------------------------------|-----------------------------------------------------|-----------------------------------------|
| <input type="checkbox"/> Nausea/vomiting | <input type="checkbox"/> Colitis                    | <input type="checkbox"/> Celiac disease |
| <input type="checkbox"/> Abdominal pain  | <input type="checkbox"/> Constipation               | <input type="checkbox"/> IBS            |
| <input type="checkbox"/> Heartburn/GERD  | <input type="checkbox"/> Crohn's                    | <input type="checkbox"/> Other: _____   |
| <input type="checkbox"/> Belching        | <input type="checkbox"/> Diarrhea                   |                                         |
| <input type="checkbox"/> Ulcer disease   | <input type="checkbox"/> Gallbladder disease/stones |                                         |

Genitourinary

- |                                                       |                                                    |                                            |
|-------------------------------------------------------|----------------------------------------------------|--------------------------------------------|
| <input type="checkbox"/> Difficulty urinating         | <input type="checkbox"/> Infertility               | <input type="checkbox"/> Kidney stones     |
| <input type="checkbox"/> Urinary incontinence         | <input type="checkbox"/> Sexual problems           | <input type="checkbox"/> Enlarged prostate |
| <input type="checkbox"/> Recurrent urinary infections | <input type="checkbox"/> Abnormal menstrual period | <input type="checkbox"/> Other: _____      |

Musculoskeletal

- |                                                |                                                         |                                       |
|------------------------------------------------|---------------------------------------------------------|---------------------------------------|
| <input type="checkbox"/> Aching muscles/joints | <input type="checkbox"/> Vertebral disc problem         | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Arthritis             | <input type="checkbox"/> Torn ligaments/muscle soreness |                                       |
| <input type="checkbox"/> Low back pain         | <input type="checkbox"/> Osteoporosis/Osteopenia        |                                       |

Endocrine

- |                                            |                                                 |                                       |
|--------------------------------------------|-------------------------------------------------|---------------------------------------|
| <input type="checkbox"/> Diabetes Mellitus | <input type="checkbox"/> Elevated cholesterol   | <input type="checkbox"/> Gout         |
| <input type="checkbox"/> Thyroid disease   | <input type="checkbox"/> Elevated triglycerides | <input type="checkbox"/> Other: _____ |

Skin

- |                                                          |                                                          |                                       |
|----------------------------------------------------------|----------------------------------------------------------|---------------------------------------|
| <input type="checkbox"/> Infection (boils, ulcers, etc.) | <input type="checkbox"/> Bruises easily                  | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Chronic rashes                  | <input type="checkbox"/> Excessive hair growth (females) |                                       |

Other

- |                                                         |                                                           |                                              |
|---------------------------------------------------------|-----------------------------------------------------------|----------------------------------------------|
| <input type="checkbox"/> Low energy level               | <input type="checkbox"/> History of child                 | <input type="checkbox"/> Sickle cell disease |
| <input type="checkbox"/> Depression, Bipolar, ADD       | <input type="checkbox"/> abuse/rape/molestation           | <input type="checkbox"/> Headache            |
| <input type="checkbox"/> Anxiety disorder, OCD,         | <input type="checkbox"/> History of any physical violence | <input type="checkbox"/> Other: _____        |
| <input type="checkbox"/> Panic attacks                  | <input type="checkbox"/> History of cancer                |                                              |
| <input type="checkbox"/> Psychological/Psychiatric care | <input type="checkbox"/> Anemia                           |                                              |

Do you have family history of the following? (check all)  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 (check all that apply):

- |                                                    |                                                   |
|----------------------------------------------------|---------------------------------------------------|
| <input type="checkbox"/> Sigmoidoscopy/Colonoscopy | <input type="checkbox"/> Mammogram                |
| <input type="checkbox"/> Cardiac Stress Test       | <input type="checkbox"/> Prostate/Testicular Exam |
| <input type="checkbox"/> Bone Density              |                                                   |

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

List current vitamins/supplements: \_\_\_\_\_

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? (choose #) \_\_\_\_\_ (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 foods do you dislike? \_\_\_\_\_

What foods do you crave? \_\_\_\_\_

What is your usual eating pattern (check all that apply):

- |                                            |                                                  |                                      |                                            |
|--------------------------------------------|--------------------------------------------------|--------------------------------------|--------------------------------------------|
| <input type="checkbox"/> varies day to day | <input type="checkbox"/> varies week vs. weekend | <input type="checkbox"/> grazer      | <input type="checkbox"/> no pattern/random |
| <input type="checkbox"/> skip meals        | <input type="checkbox"/> nighttime eating        | <input type="checkbox"/> 3 meals/day | <input type="checkbox"/> 3 meals + snacks  |

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

How would you rate your cooking skills? (choose #) \_\_\_\_\_ (Inexperienced 1 2 3 4 5 Skilled)

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? \_\_\_\_\_

How often do you travel? \_\_\_\_\_

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? (check all that apply)

- time of day    hunger    seeing/smelling food    emotions    boredom    other

Do any religious practices or food philosophies affect your diet (ex: Kosher, Vegetarianism)? (describe)

\_\_\_\_\_

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 the following? (check all that apply)

- compulsive over eating    binge eating disorder    anorexia    bulimia    other

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

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? How often? (describe)

\_\_\_\_\_

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 or shortness of breath 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