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Date:

Intake Form

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name: __ M __ F		**AGE:**
Address:		**DOB:**
Home Phone:	**Cell Phone:**	**Work:**
City/State/Zip:		**Fax:**
Email Address:		
Occupation:		
Marital status: __ Single __ Partnered __ Married __ Separated __ Divorced __ Widowed		
# of Children:	**Ages of Children:**	
Height:	**Weight:**	
Referred by:		
WOMEN ONLY		
# of Births:	**Complications:**	
# of Miscarriages:	**C-Sections:**	
Menopause:	**Other:**	

Present Complaint or Illness and Duration

SURGERIES		
Year	**Reason**	**Hospital**

ACCIDENTS		
Year	**Reason**	**Hospital**

MEDICAL HISTORY: Check any disease which you or your relatives have had.

VITAMINS, MINERALS, HERBS, SUPPLEMENTS, ETC.		
Name	**Strength**	**Frequency Taken**

PRESCRIPTION DRUGS		
Name	**Strength**	**Frequency Taken**

ALLERGIES	
Cause or Medication	**Reaction You Had**

HEALTH QUESTIONS							
How much coffee do you drink:			Cups per week:		Decaf or Regular:		
How much tea do you drink:			Cups per week:		Decaf or Regular:		
How much alcohol do you drink:			Drinks per day:		Drinks per week:		
What is your relationship with sugar? Often:	Binge:	Moderately:	Rarely:	None:	Binge:	Daily:	Weekly:
Do you exercise regularly?							
If so, what does a typical week look like?							
Do you smoke cigarettes?	If so, how much?		Did you ever smoke?				
Do you use artificial sweeteners?	If so, which one?		How much?				
How do you relax?							
How often do you have bowel movements?	Daily?		Weekly?				
How often do you have constipation?	Or diarrhea		Or both				
Have you ever worked in an environment where you were exposed to pesticides, chemicals, or heavy metals?							

WOMEN ONLY		
Do you still have menstrual periods?	Number of Days between periods?	Length?
Do you use contraceptive?	What type?	
Are you taking estrogen replacement therapy?		
Do you get up during the night to urinate?	If so, how often?	
MEN ONLY		
Do you get up during the night to urinate?	If so, how often?	
Are you having problems getting or maintaining an erection?		

CHECK ANY OTHER ILLNESSES YOU HAVE OR HAVE HAD. P = past or C = current

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

____	Abscesses	____	Diverticulitis	____	Herniated Disc	____	Numbness
____	Acne	____	Drug Addiction	____	Herpes	____	Pancreatitis
____	Aids	____	Ear Infections	____	High Blood Pressure	____	Persistent Cough
____	Alcoholic	____	Eczema	____	Hives	____	Pneumonia
____	Allergies	____	Emphysema	____	Insomnia	____	Polio
____	Alopecia/Hair Loss	____	Endometriosis	____	Jaundice	____	Psoriasis
____	Anemia	____	Excessive Fatigue	____	Kidney Stones	____	Rheumatic Fever
____	Attempt Suicide	____	Eye Disease	____	Liver Disease	____	Rheumatoid Arthritis
____	Arteriosclerosis	____	Fainting or Dizzy Spells	____	Low Blood Pressure	____	Scarlet Fever
____	Back Problems	____	Gall Stones	____	Lupus	____	Sciatica
____	Benign Breast Tumor	____	Gastritis	____	Major Surgery	____	Skin Ulcers
____	Bleeding Gums	____	Gingivitis	____	Malaria	____	Skipped Heart
____	Bronchitis	____	Goiter	____	Measles	____	Stroke

____	Candida Albicans	____	Gonorrhea	____	Mononucleosis	____	Syphilis
____	Cataracts	____	Hay Fever	____	Multiple Sclerosis	____	Thyroid Disease
____	Chest Pains	____	Hearing Problems	____	Mumps	____	Ulcerative Colitis
____	Chicken Pox	____	Hemorrhoids	____	Myopia	____	Vision Problems
____	Cirrhosis	____	Hepatitis	____	Nervous Breakdown	Other:	
____	Crohn's Disease	____	Hernia	____	Nervousness		
____	Depression	____	Headaches	____	Neuralgia		
____	Diphtheria			____	Night Blindness		

One Day Food Diary – On this page please write down your food intake in the last two days. This information will help me focus on your likes, dislikes, patterns, strengths, and gaps. Thanks.

Day #1 [Click here to enter a date.]
Beverages
Supplements

Insurance Information

Primary Insurance Company _____ Phone Number _____ Subscriber _____ Birthdate _____ Group Number _____

Secondary Insurance Company _____ Phone Number _____ Subscriber _____ Birthdate _____ Group Number _____

As a courtesy to our patients, we will file your insurance claim with the insurance company listed above for the consult you receive. However, in the event the insurance company, for any reason, does not pay, the balance will become your responsibility, and will be billed directly to you. You understand that this contract is with Sahar S Berjis and yourself, and you are responsible for all charges on the account.

SIGNATURE OF RESPONSIBLE PARTY

_____ Relationship

_____ Date _____

For Office Use Only:

We attempted to obtain written acknowledgement of receipt of our NOTICE OF PRIVACY PRACTICES, but acknowledgment could not be obtained because of:

____ Individual refused to sign ____Communication barriers prohibited ____Emergency Situation

____Acknowledgement not returned by parent. HIPAA information given

CLIENT INFORMED CONSENT & STATEMENT OF INTENT

I, Sahar S Berjis, RD, MPH, am a Licensed Dietitian. I have worked in the field of nutrition and health education since 2002. I am a health educator, NOT A PHYSICIAN. As such, I do not diagnose or treat disease; rather I help support the innate healing response of the body through food, nutritional supplements, relaxation & visualization, and exercise programs.

I, the Client, understand that information provided on the relationship between nutrition and health is NOT meant to replace competent medical care or treatment for any health problem or condition. I understand that a Nutritional Assessment and Evaluation is not done to define health as it relates to disease, but as it relates to wellness.

I, the Client, choose to improve my health by assuming greater self-responsibility to reduce or eliminate unhealthy behaviors that are contrary to my well being. The Surgeon General (1990) estimated that 7 out of the 10 leading causes of death in America are related to lifestyle habits; diet, smoking, lack of exercise, and substance abuse. They are the focal points of our work together.

I, the Client, understand and acknowledge that the services provided are private and confidential. All information whether oral, written, printed, photographic, or electronic is strictly confidential and protects you by federal and state laws that prohibit unauthorized use or disclosure. No information will be released without your consent.

I certify that I am here solely on my own behalf. I am not representing any other person, company, association, and/or on the behalf of any governmental agency.

I currently am___ am not____ under the care of a physician for a health problem or medical condition. If so, for what problem or condition?

Sahar Berjis, RD, MPH, has my, the Client's, permission to contact my physician about the work we are doing and to obtain client/patient records.

My physician is: _____

_____ _____

Client signature Date

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