Jenny Askew, MS, RD, LD, ACSM-HFS
Balance Fitness and Nutrition, LLC
Email: jenny@bfan.us Phone: 678-203-1513 Fax: 678-550-9518

My ability to draw effective conclusions about your child's state of health and how to improve it depends, to a significant extent, on your ability to respond thoughtfully and accurately to these questions. Health issues are usually influenced by several factors. Accurately assessing all the factors and comprehensively managing them is the best way to deal with your health challenges.

To enhance your consultation:

- Please return this form to our office least one day prior to your appointment. You can scan and email to info@bfan.us or fax to (678) 550-9518.
- Please bring a copy of all lab work completed in the last year, and any other labs you feel may be relevant.
- Please bring all medication and supplement bottles to appointment.

Contact information

Child's name: _____ Date of first appointment: _____ Age: _____

DOB: _____ Place of Birth: _____Gender: _____

Height or Length: _____ Weight: _____ Ethnicity: _____

How did you find out about our practice? _____ May we add you to our emailing list? Yes No

Mother's Name (or Guardian):_____

Address: _____ E-mail Address: _____

Telephone Number H: _____ W: _____ C: _____

Age: _____ Occupation: _____

Father's Name (or Guardian):_____

Address: _____ E-mail Address: _____

Telephone Number H: _____ W: _____ C: _____

Age: _____ Occupation: _____

Please indicate current parental situation and who the child lives with: _____

Please rank current problems by priority and fill in the other boxes as completely as possible:

DESCRIBE PROBLEM	MILD/MODERATE/SEVERE	TREATMENT APPROACH	SUCCESS
EXAMPLE: POST NASAL DRIP	Moderate	Elimination Diet	**MODERATE**

Please check any other problems:

Speech	Immaturity	Learning disability
Behavior	Sweet tooth	Fatigue
Short attention span	Craves junk food	Excessive fluid intake
Academic problems	Fear, Anxiety	Poor coordination
Bed wetting	Allergies	Hyperactivity
Mood swings	Poor peer relations	
Other:		

PRECONCEPTION INFORMATION:

Please circle yes or no, explain any 'yes' answers.

1. Were any medications taken 3 years prior to pregnancy by mother or father? Yes No
2. Were there any serious illnesses prior to pregnancy? Yes No
3. Did either parent suffer a nervous breakdown prior to pregnancy or since? Yes No

PRENATAL INFORMATION:

4. Apgar rating (if known):
5. Were forceps used during birth? Yes No
6. Was vacuum extraction used during birth? Yes No
7. Did mother or baby have thrush, yeast, or candida infection? Yes No
8. Please explain anything unusual about the birth:

POST NATAL DEVELOPMENT:

9. Did baby have early feeding problems? Yes No

10. Did child hit developmental milestones at appropriate times? Yes No

11. Was baby colicky? Yes No

12. Did/ does baby bang head frequently? Yes No

MATERNAL HISTORY:

13. Please check the appropriate box regarding mother's health history, and explain any 'yes' answers in the space below.

	1st Trimester **(conception to 3rd mo.)**		2nd Trimester **(4th – 7th mo.)**		3rd Trimester **(7th mo. to birth)**	
Did mother have…	**YES**	**NO**	**YES**	**NO**	**YES**	NO
Medications						
X-Rays						
Infectious Diseases						
High Blood Pressure						
Severe Nausea/ Vomiting						
Serious Emotional Upsets						
Injuries						
Hospitalizations						
Abnormal Weight Gain						
Hemorrhage						
Spotting						
Swelling of feet						
Exposure to Viral Diseases						
Albumin in urine						
Toxemia						
Other Disorders						

PERINATAL INFORMATION:

Please circle yes or no, explain any 'yes' answers.

14. Where was child born?

15. Birth Weight:

16. Length of labor:

17. Was baby born pre-mature? Yes No

18. Was labor difficult? Yes No

19. Was labor induced? Yes No

20. Was labor delayed? Yes No

21. Was this a Cesarean birth? Yes No

22. Was baby a twin? Yes No

23. Did baby require more than routine oxygen at birth? Yes No

24. Was baby discolored at birth? Yes No

25. Were there any other observable abnormalities of baby at birth? Yes No

26. Did baby need treatments immediately after birth? (i.e. tube feedings, surgery) Yes No

27. Did baby have sucking problems at birth or since? Yes No

If yes, please explain:

POST NATAL INFORMATION:

28. Did baby have early feeding problems? Yes No

29. At what age was child toilet trained?

Was difficulty encountered? Yes No

MEDICAL HISTORY:

30. Give approximate age child had any of the following diseases:

Chicken Pox	Measles (Red)	Measles (German)
Roseola	Mumps	Whooping cough
Influenza (flu)	Mononucleosis	Scarlet fever
Rheumatic fever	Hepatitis	Pneumonia
Tuberculosis	Encephalitis	Epilepsy
Nervousness	Nervous breakdown	Emotional problems
Fainting spells	Heart palpitations	Shortness of breath
Other		

Please describe any unusual complications of those listed above:

31. Has child ever had injuries? Yes No

32. Has child ever had any operations? Yes No

33. Please list family disease history

Mother's side:

Father's side:

34. Please check any *current* medical issues:

ILLNESS	AGE OF ONSET	COMMENTS
Anemia (type)		
Arthritis		
Asthma		
Bronchitis		
Cancer		
Crohn's Disease or Ulcerative Colitis		
Diabetes		
Epilepsy, Convulsions, or Seizures		
Heart murmur		
OTHER (PLEASE LIST):		

EDUCATION & SOCIAL HISTORY:

35. Is your child presently enrolled in school? Yes No

If yes, please describe type of school and school situation:

36. Has child ever been held back a grade? Yes No

37. Is child an over or under-achiever?

38. What are child's hobbies and leisure activities?

39. Has child ever lived outside of the United States? Yes No

40. Has the child or family recently experienced any major life changes? Yes No

41. Has child experienced any major stress or losses in life? Yes No

42. Please list siblings in order of birth (include patient):

Name	Gender	Age	Health Status	Adopted?

REVIEW OF SYSTEMS

Please circle yes or no and explain any 'yes' answers.

Does your child suffer from any of the following…

STOMACH & INTESTINAL:

43. Stomach or Intestinal disorders? Yes No

44. Anal itching? Yes No

45. Please check the appropriate box below with information about child's recent bowel movements:

Frequency	Color	Consistency
More than 3x daily	Dark brown	Soft and well formed
2-3x daily	Medium brown	Often float
1x daily	Very dark or black	Difficult to pass
4-6x per week	Greenish	Diarrhea
2-3x per week	Blood visible	Thin, long or narrow
1x or less per week	Yellow or light brown	Small and hard
	Greasy or shiny appearance	Loose, but not watery
	Varies a lot	Varies a lot

SKIN & SKELETON:

46. Skin disorders? (i.e. eczema, excessive dryness, burns) Yes No

47. Athlete's foot? Yes No

48. Bone or joint disorders? (i.e. arthritis) Yes No

ENDOCRINE:

49. Issues being over or underweight: Yes No

50. Diabetes? Yes No

51. High or low blood sugar? Yes No

52. Thyroid imbalance? Yes No

53. Menstrual disorder? Yes No

54. Late, early, or abnormal sexual development? Yes No

HEART AND LUNGS:

55. Chronic cough? Yes No

56. Bronchial disorder? Yes No

57. Heart disorder? Yes No

58. Heart murmur? Yes No

59. Lung disorder? Yes No

CENTRAL NERVOUS SYSTEM:

60. Reoccurring headaches or dizziness? Yes No

61. Coordination problems? Yes No

62. Head or brain injury? Yes No

63. Nerve or muscle disorders? Yes No

64. Seizure disorders? Yes No

SPEECH AND AUDITORY:

65. Speech problems Yes No

66. Difficulty hearing? Yes No

67. Is child exceptional in music ability? Yes No

EARS, NOSE, AND THROAT:

68. Ear disorders? Yes No

69. Nose disorders? Yes No

70. Throat disorders? Yes No

DENTAL HISTORY

Please circle yes or no and explain any 'yes' answers.

71. Does child have amalgam (silver, black, or grey) fillings? Yes No

72. Has child ever had fillings replaced? Yes No

73. Has child had any root canals? Yes No

74. Has child had any cavities in the last 2 years? Yes No

75. Do child's gums ever bleed? Yes No

76. Does child grind their teeth? Yes No

ALLERGY & TOXIC POTENTIAL:

Please circle yes or no and explain any 'yes' answers.

Does your child have any of the following…

77. Food allergies or intolerances?	Yes	No
78. Drug/medication allergies?	Yes	No
79. Environmental allergies?	Yes	No
80. Intolerance to odors such as perfumes, cleaning solutions, or smoke?	Yes	No
81. Exposure to toxic metals ex: lead, cadmium, arsenic, mercury, aluminum or asbestos?	Yes	No
82. Exposure to solvents, paints, pesticides, petrochemicals, coal, hydrocarbons or mold?	Yes	No
83. Exposure to paints, glues or dyes from participating in past hobbies?	Yes	No
84. Exposure to regular lawn care service?	Yes	No
85. Pets or farm animals?	Yes	No
86. Bug spray or insecticides exposure on a regular basis?	Yes	No
87. Second hand smoke exposure (past or present)?	Yes	No

BEHAVIORAL AND EMOTIONAL CHARACTERISTICS

Please circle yes or no and explain any 'yes' answers.

Does your child…

88. Seek company of younger children?	Yes	No
89. Seek company of older children?	Yes	No
90. Annoy or antagonize other children?	Yes	No
91. Bite nails?	Yes	No
92. Have a fear of the dark?	Yes	No
93. Suffer from being very shy?	Yes	No
94. Seem unusually active, distractible, destructive or tired?	Yes	No
95. Have a history of being considered dangerous?	Yes	No
96. Have poor social adjustment to family, classmates or teachers?	Yes	No
97. Have rapidly changing behavior? One hour pleasant and the next disagreeable?	Yes	No
98. Respond to a change of surroundings by making distinct changes in behavior?	Yes	No

LIFESTYLE INFORMATION

99.	Exercise regularly?	Yes	No
100.	Need more sleep than most?	Yes	No
101.	Have trouble getting to sleep or staying asleep?	Yes	No
102.	Ever need to take a sleep aid?	Yes	No
103.	Take OTC medications on an ***occasional*** basis?	Yes	No
104.	Have a history of prolonged antibiotic use?	Yes	No
105.	Have a history of taking oral steroids, such as Prednisone?	Yes	No
106.	Have a history of being on any medication for longer than two weeks?	Yes	No
107.	Swallow pills?	Yes	No

108. What is child's usual bed time? Wake time?

109. Check off typical bedtime activities: □ Watch television □ Read a book □ Listen to music □ Bed time snack □ Bathe/shower □ Other:

110. What type of activities is child involved in (i.e. dance, soccer, gymnastics, tennis, etc.)?

111. How much sun exposure does child get on a daily or weekly basis?

112. What percentage of the time does child wear sunblock?

MEDICATIONS & SUPPLEMENTS

Please list any medications child is taking on a *daily/regular* basis:

MEDICATION NAME	PURPOSE	DOSAGE	START DATE

Please list all vitamins, minerals, and other nutritional supplements child is taking on a *daily/regular* basis. Indicate dosage (mg or IU), and form (i.e. calcium carbonate vs. calcium lactate).

******PLEASE BRING BOTTLES TO APPOINTMENT******

VITAMIN/MINERAL/SUPPLEMENT	BRAND NAME	DOSAGE	START DATE

Please describe any difficulties encountered when giving medication and/or vitamins:

DIETARY HABITS:

Please circle yes or no and explain any 'yes' answers.

Does your child…

113. Require a special diet? Yes No

114. Avoid certain foods? Yes No

115. Crave certain foods? Yes No

116. Enjoy eating? Yes No

117. Have adverse symptoms immediately after eating? Yes No

118. Have delayed adverse symptoms after eating? Yes No

119. Please explain any correlations you have noticed between foods consumed and adverse reactions in your child:

Example: I have noticed milk causes gas.

120. What is child's usual:

Breakfast time: Lunch time: Dinner time: Snacks time(s):

Place a mark next to the foods and drinks that apply to a typical day of child's diet:

Breakfast	Lunch	Dinner
None	None	None
Cereal	Eat in cafeteria	Pasta
Wheat bran	Eat in restaurant	Potato
Oatmeal	Leftovers	Brown rice
Toast	Meat sandwich	White rice
Bagel	Fish sandwich	Beans (legumes)
Sweet roll	Lettuce (on sandwich)	Fish
Donut	Tomato	Red meat
Eggs	Salad	Poultry
Bacon/sausage	Salad dressing	Salad
Fruit	Soup	Salad dressing
Yogurt	Fruit	Green vegetables
Milk	Yogurt	Carrots
Juice	Milk	Yellow vegetables
Water	Juice	Milk
Butter	Water	Juice
Margarine	Regular soda	Water
Sugar	Diet soda	Regular soda
Sweetener	Butter	Diet soda
Leftovers	Margarine	Butter
Other:	Mayonnaise	Margarine
Other:	Sugar	Sugar
Other:	Sweetener	Sweetener
Other:	Other:	Other:
	Other:	Other:
	Other:	Other:
	Other:	Other:

121. If your child could plan their day, what would it be like?

Time of awakening:	Breakfast:
Activity:	Snack:
Activity:	Lunch:
Activity:	Snack:
Activity:	Dinner:
Activity:	Snack:
Bedtime:	

122. Who is the primary cook for the household?

123. On a scale of one through five, how much does he or she enjoy cooking?

1_____5
Loves cooking! Hates cooking!

124. What do you think might lie at the root of your child's health issues?

125. What does your child need in order to heal?

126. Is there anything else you think we should know? You may use the rest of this page (and the back of this page if needed) to detail your main concerns and what you expect to get out of working together:

Balance Fitness and Nutrition

HIPPA Notice of Privacy Practices

The entirety of the HIPPA Privacy Notice is available on our website and by request at our office.

Patient Written Acknowledgment Confirming Receipt of Privacy Notice

I have received a HIPPA Privacy Notice from Balance Fitness and Nutrition, LLC.

_____

Client signature

_____

Printed name of client

_____

Signature of parent or guardian if client is less than 18 years of age:

_____

Date

Balance Fitness and Nutrition

HIPPA Communication Authorization

On this form, please indicate your preferences for communication below.

Email communications

_____ **Yes, please communicate with me by Email**. Email communications may include test results, answers related to questions you have about your diet or health conditions.

By checking yes, I acknowledge that I have been notified that there is some level of risk that protected health information transmitted email could be read by someone other than me. My email address is:

_____

_____ **No, please do not email me**

Texting communications

_____ **Yes, please communicate with me by text**. Text communications may include answers to questions you have about your diet or health related conditions.

By checking yes, I acknowledge that I have been notified that there is some level of risk that protected health information transmitted by text could be read by someone other than me. My cell phone number is:

_____

_____ **No, please do not communicate with me by text**

Signature: _____ **Date:** _____

You have the right to revoke this authorization at any time by contacting us in writing.

Balance Fitness and Nutrition
Disclaimer of Liability

The dietitians at Balance Fitness and Nutrition, LLC are not physicians or psychologists, and the scope of their consultation services does not include treatment or diagnosis of specific illnesses or disorders. If you, the client, suspect you may have an ailment or illness that may require medical attention, consult with a licensed physician without delay. Only a licensed physician can prescribe drugs. Any mention of drugs in the course of consultation is only for the purpose of providing a complete history of drugs that the client is taking and not for Balance Fitness and Nutrition, LLC to judge the appropriateness of the medication. Any change in prescription or dosage is a decision the client makes with his or her physician.

Rather than dealing with treatment of disease, Balance Fitness and Nutrition, LLC focuses on wellness and prevention of illness through the use of non-toxic, natural nutritional therapies to achieve optimal health. The registered dietitians at Balance Fitness and Nutrition, LLC primarily educate and motivate clients to assume more personal responsibility for their health by adopting a healthy attitude, lifestyle, and diet. While people generally experience greater health and wellness as a result of embracing a healthier attitude, lifestyle, and diet, Balance Fitness and Nutrition, LLC does not promise or guarantee protection from future illness.

By signing below, you acknowledge that you understand that Balance Fitness and Nutrition, LLC is a health consultant and not a physician, and that you should see a doctor if you think you have a medical condition. Balance Fitness and Nutrition, LLC will not be held liable for failure to diagnose or treat an illness, nor will Balance Fitness and Nutrition, LLC be liable for failure to prevent future illness.

Additionally, you promise to give your registered dietitian at Balance Fitness and Nutrition, LLC a complete and accurate account of any medical conditions that you may have and any medications that you are taking. For questions or comments regarding these policies, please contact Jenny Askew through email at jenny@bfan.us or by phone at (678) 203-1513.

_____
Client signature

_____
Printed name of client

_____
Signature of parent or guardian if client is less than 18 years of age:

_____
Date

Balance Fitness and Nutrition

Physician Contact Information

Primary Care Physician

Name	Phone #:	Fax #:
Address:		
Relationship with Physician (i.e. what do you seen him/her for, when was your last apt, etc.)		

Additional health care providers that you see for any ongoing issues:

Type of health care provider:		
Name	Phone #:	Fax #:
Address:		
Relationship with provider (i.e. what do you seen him/her for, when was your last apt, etc.)		

Type of health care provider:		
Name	Phone #:	Fax #:
Address:		
Relationship with provider (i.e. what do you seen him/her for, when was your last apt, etc.)		

Type of health care provider:		
Name	Phone #:	Fax #:
Address:		
Relationship with provider (i.e. what do you seen him/her for, when was your last apt, etc.)		

☐ **I give my registered dietitian at Balance Nutrition, LLC permissions to speak with and disclose my protected health information with the above named treatment providers.**

☐ **I do <u>not</u> give my registered dietitian at Balance Nutrition, LLC permissions to speak with and disclose my protected health information with the above named treatment providers.**

Client Signature: _____ Date: _____
Printed name of client: _____

Signature of parent or guardian if client is less than 18 years of age: _____

Balance Fitness and Nutrition

Payment & Cancellation Agreement

- All Services may be paid with cash, check, or credit card. Please make all checks payable to Balance Fitness and Nutrition, LLC.
- Balance Fitness and Nutrition, LLC does not accept insurance. However, you may request paperwork if you wish to file a claim to your insurance company for reimbursement purposes.
    - Handling of all paperwork for insurance purposes must be done during your appointment. If you request paperwork outside of appointment time, there will be a $15.00 charge.
- All appointment cancellations must be completed 24 hours in advance. Failure to cancel an appointment within 24 hours will require full payment for the cost of the scheduled appointment.
- There will be a $30.00 charge for all returned checks.
- Appointments start on time. If you arrive late, you will be seen for the time remaining in your visit, but will still pay the full price of your visit.
- Packages of sessions expire after six months. Balance Fitness and Nutrition, LLC does not provide refunds for packages of other services under any circumstances.

I understand that I must comply with the payment and cancellation policies listed above when working with Balance Fitness and Nutrition, LLC. This respects the time and expertise provided by Balance Fitness and Nutrition, LLC and will help me to make progress on the goals and plans that I have committed to.
By signing this agreement, I am indicating that I understand these policies and agree to adhere to them. I also understand that the recommendations and education provided by the registered dietitians at Balance Fitness and Nutrition, LLC should not be used in place of medical advice.
For questions regarding these policies, please contact Jenny Askew at jenny@bfan.us or 678-203-1513.

_____
Client signature

_____
Printed name of client

_____
Signature of parent or guardian if client is less than 18 years of age:

_____
Date