Balance Fitness and Nutrition, LLC

Email: info@bfan.us

Phone: 678-203-1513 Fax: 678-550-9518

My ability to draw effective conclusions about your present 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

Name: ____ Date of first appointment: ______________

Home address: ____

Date of birth: ___________ Age: ______________ Place of birth: ___________________________________

Ethnicity: ________________________________

Telephone Number H: _______________________ W: _______________________ C: _________________

Email: ____ Occupation: _______________________________

How did you find out about our practice? ____

May we add you to our emailing list? Yes No

Height and Weight Information

Height:__________ Weight:__________

Desired Weight: __________ Last age at desired weight: __________

Lowest adult weight: __________ Age at lowest adult weight: __________

Highest Adult Weight: __________ Age at highest adult weight: __________

Current concerns

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

Health issue	Mild, Moderate or Severe	Past	Success
Example: Post Nasal Drip	Moderate	Elimination Diet	Moderate
a.			
b.			
c.			
d.			

Family and Medical History

1. Please indicate significant family medical history (ex: cancer, diabetes, heart disease, etc.)
   Maternal side:

   Paternal side:

2. Are your parents living? Yes No
   If no, please explain:

3. Did you have any health issues as a child? Yes No
   If yes, please describe your health issues and the age(s) at which your health issues occurred:

4. As a child were there foods you avoided? Yes No
   If yes, please complete the table below:

Food	Symptoms
Ex: Milk	Ex: Gas and diarrhea

5. Past medical and surgical history

ILLNESSES	WHEN	COMMENT

a) Anemia (type)		
b) Arthritis		
c) Asthma		
d) Bronchitis		
e) Cancer		
f) Chronic Fatigue Syndrome		
g) Crohn's Disease or Ulcerative Colitis		
h) Diabetes		
i) Emphysema		
j) Epilepsy, Convulsions or Seizures		
k) Gallstones		
l) Gout		
m) Heart Attack/Angina		
n) Heart Failure		
o) Hepatitis		
p) High Blood Fats (cholesterol,		
q) High Blood Pressure (hypertension)		
r) Irritable Bowel		
s) Kidney stones		
t) Mononucleosis		
u) Pneumonia		
v) Sinusitis		
w) Sleep Apnea		
x) Stroke		
y) Thyroid disease		
z) Other (describe)		
INJURIES		
a) Back injury		
b) Broken Bones		
c) Head Injury		
d) Neck Injury		
e) Other (acute) ex: sprained muscle		
f) Other (chronic) ex: bad knees		
DIAGNOSTIC STUDIES		
a) Bone Scan		
b) CAT Scan		
c) EKG		
d) MRI		
e) Upper/Lower GI Series		
f) Other (describe)		
OPERATIONS		
a) Dental Surgery		
b) Gallbladder		
c) Hysterectomy		
d) Tonsillectomy		
e) Other (describe)		

Gastrointestinal Health

6. Please mark in the chart below with information about 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

7. Do you experience intestinal gas?
   Present with pain Foul smell Little odor Excessive daily Occasionally

8. Do you experience anal itching?
   Frequently Occasionally Rarely Never

9. Do you experience any heartburn, chest pressure, or stomach pain? Yes No
   If yes, please list anything you take for relief:

WOMEN ONLY: (Questions 10-17)

10. Have you ever been pregnant? Yes No

    If yes, please provide the following information:
    Number of miscarriages: Number of abortions: Birth weight of largest baby:
    Number of term births: Number of preemies: Birth weight of smallest baby:

    Did you ever develop toxemia during pregnancy? Yes No

    If you have had other issues with pregnancy, please describe:

11. Age of first menses:
12. Date of last Pap smear:
    Were findings normal? Yes No
13. Date of last Mammogram
    Were the findings normal? Yes No
14. Do you currently use contraception? Yes No
    If yes, what kind of contraception do you use?

15. Are you currently taking birth control pills? Yes No
If yes, please comment on physical or mental changes from before taking to now:

16. Are you experiencing menopause symptoms? Yes No

17. Do you take any of the following:
Estrogen Estrace Premarin Other:

---

18. Do you have urinary problems? Yes No

If yes, please indicate:

Nightly urination	Hesitancy	Irregular
Dribbling afterwards	Frequent urges	Difficulty
Incomplete emptying	Burning sensation	

Dental health

Please answer the following questions related to dental health:

19. Do you have amalgam (silver, black or grey) fillings? Yes No
If yes, how many?

20. Have you ever had fillings replaced? Yes No
If yes, please indicate how many, when they were replaced, and the material used in the replacement:

21. Do you have root canals? Yes No
If yes, please indicate how many root canals you have had. Also, please comment if you have had any problems:

22. Have you had any cavities in the last 2 years? Yes No
If yes, how many?

23. Do your gums ever bleed? Yes No
If yes, how often?

24. Do you ever grind your teeth? Yes No

25. Do you have artificial joints or implants anywhere in your body? Yes No
If yes, please explain:

Social health

26. With whom do you live? List age of children, if any:

27. What is the attitude of those close to you concerning your health?

    Supportive   Not supportive   Indifferent

28. Rate the status of each aspect in your life right now in the chart below:

	Great	Good	Could be better	Not very good	Does not apply
School					
Job					
Social life					
Close friends					
Sex					
Your attitude					
Significant other					
Children					
Parents					

29. What are your hobbies and leisure activities?

30. Describe previous jobs/work:

31. What is your total amount of airline trips?

    In the last year:

    Estimated total in life:

    Number of trips out of the country:

32. Are you currently married, or have you ever been married? Yes No

    If yes, please indicate how long you have been married and your spouse's occupation:

33. Have you been separated or divorced? Yes No

    If yes, please indicate when

34. Have you lived outside of the United States? Yes No

    If yes, please indicate where and when you lived outside of the United States:

35. Have you experienced any major losses in your life? Yes No

    If yes, please comment

36. Have you or your family recently experienced any major life changes? Ex: job change, moving, etc. Yes No

    If yes, please comment

37. Have you ever had psychotherapy or counseling? Yes No
If yes, please indicate what type and when:

Lifestyle

38. How important is religion or spirituality to you?
Not at all important | Somewhat important | Extremely important

39. Do you meditate?
Often | Occasionally | Never

40. On a scale of 1-10, how much control do you feel you have over your current state of health?
1 ____________ 5 ____________ 10
No control ... Complete control
Please comment:

41. How much time have you lost from work or school in the past year due to illness?
0-2 days | 3-5 days | 6-14 days | More than 14 days

42. What times do you usually go to bed and wake up?

43. How well do you sleep? Please mark all that apply:

Adequately	Wake up tired	Trouble staying asleep
Wake up feeling well rested	Trouble falling asleep	

44. What are your usual bed time activities? Please mark all that apply:

Watch television	Listen to music	Take a shower
Read a book	Meditate	Drink alcohol
Drink a caffeinated beverage	Other:	

45. Do you ever need to take a sleep aid? Yes No
If yes, please indicate what you take, how much, and how often:

46. Do you currently have an exercise routine? Yes No

47. Do you have a history of maintaining an exercise routine in the past? Yes No

48. Do you get sun exposure? Yes No
If yes, please indicate how long and how many days per week:

49. When is the last time you had your vitamin D level checked?
What level was your vitamin D?

50. In which of the following exercises do you participate?
    Jogging Walking Weight training Water sports Aerobics Yoga
    Other:

51. How often do you exercise?
    Once per week Twice per week Three times per week Four times per week or more

52. For how long do you exercise?
    Less than 15 minutes 15-30 minutes 30-45 minutes More than 45 minutes

Allergy and Toxin Potential

53. Do you have any pets or farm animals? Yes No
    If yes, please list the types of animals you have and whether they live inside or outside:

54. Do odors such as perfume, cleaning solutions, smoke, etc. affect you? Yes No
    If yes, please explain:

55. Do you now, or have you recently lived in a home built before the 1970's? Yes No
    If yes, please indicate how old the home was and how long you lived there:

56. Have you ever lived or worked in a water damaged building? Yes No
    If yes, please indicate when you lived or worked there and for how long:

57. Have past activities/hobbies exposed you to photography chemicals, paints, glues, or dyes? Yes No
    If yes, please explain:

58. Do you have a regular lawn care service? Yes No
    If yes, please provide the frequency of service:

59. Do you regularly spray for pests outdoors? Yes No
    If yes, how often do you spray?

60. Do you use bug spray or insecticides on a regular basis? Yes No
    If yes, please indicate how often:

Yes No

61. Have you ever used tobacco?
    If yes, please specify the amount per day and the length of time you have used tobacco:

    If you have a history of tobacco use, what year did you quit?

62. Are you now, or have you ever been exposed to second hand smoke? Yes No
    If yes, when were you exposed?

63. Have you ever used recreational drugs? Yes No
    If yes, please specify:

64. To your knowledge, have you been exposed toxic metals at your job or at home?

No exposure	Mercury
Lead	Aluminum
Cadmium	Other:
Arsenic	

65. To your knowledge, have you ever been exposed to an ongoing amount of any of the following?

No ongoing exposure	Coal
Solvents	Hydrocarbons
Paints	Mold
Pesticides	Other:
Petrochemicals	

66. How often do you wear dry cleaned clothing?

67. How often are you exposed to burning coal, bonfires, fire pits, or similar?

68. Please indicate current and past **weekly** alcohol consumption:

Current:	0 drinks	1-3 drinks	4-6 drinks	7-10 drinks	10+ drinks
Past:	0 drinks	1-3 drinks	4-6 drinks	7-10 drinks	10+ drinks

Medications

69. Please list all prescribed medications you are currently taking.

Medication Name	Purpose	Dosage	Start Date
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

70. Do you take any over the counter medications on an occasional basis? Yes No
    If yes, please list:

71. Were you ever on antibiotics for a prolonged period of time such as months or years? Yes No
    If yes, please explain:

72. How many times have you taken antibiotics as an infant or child?
    Less than 5 times More than 5 times More than 10 times So many times I lost count

73. As an adult, how often do you take antibiotics?
    Never Once a year Twice yearly Three time yearly More than three yearly

74. Fill in the chart below for how many times have you taken oral steroids. Examples of oral steroids include Cortisone and Prednisone.

	Less than five times	Greater than five	Greater than 10 times
Infancy/Childhood			
Teen			
Adulthood			

75. List all vitamins, minerals, and other nutritional supplements that you are currently taking. Indicate unit (mg or IU), and form (for example: calcium carbonate vs. calcium lactate).

Vitamin/Herbal Supplement(s)	Brand	How Many and When?	Start Date
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			

****If you are being seen in person, please bring supplement bottles with you to your appointment****

Dietary Habits

76. **Have you ever dieted?** Yes No
    If yes, how many times in your adult life?

    Which diets worked and what did you like about each diet?

77. Are you currently on a special diet? Yes No
    If yes, please explain the type of diet and how long you have been following the diet: :

78. Do you avoid certain foods for any reason? Yes No
    If yes, please explain:

79. Do you ever binge on certain foods? Yes No

    If yes, please identify the foods and any possible triggers:

80. Do you currently or typically have any symptoms immediately after eating? Symptoms may include belching, fatigue, bloating, sneezing and hives. Yes No

    If yes, please explain and identify any foods you suspect may cause your symptoms:

81. Do you feel you have delayed symptoms after eating certain foods? Symptoms may include fatigue, muscle aches and sinus congestion. Delayed symptoms may not be evident for 36 hours or more after eating. Yes No

    If yes, please explain and identify any foods you suspect may cause your symptoms:

82. Do you feel worse at certain times of the year? Yes No

    If yes, please explain:

83. Do you feel better at certain times of the year? Yes No

    If yes, please explain:

84. Does skipping a meal affect you in any way? Yes No

    If yes, please explain:

85. Do you feel much worse when you eat a lot of:

    High fat foods
    Refined sugar (junk foods)
    High protein foods
    Fried foods
    High carbohydrate foods
    One or two alcoholic drinks
    Other

Do you feel much better when you eat a lot of:

High fat foods
Refined sugar (junk foods)
High protein foods
Fried foods
High carbohydrate foods
One or two alcoholic drinks
Other

Food Journal

Please fill out the table below to the best of your ability. Aim at being accurate and descriptive with types and amounts of food eaten. List all beverages, including water and alcoholic beverages consumed throughout the day.

Food consumed on a typical weekday

Time	Food / Beverage Consumed	Amount Eaten	Hunger levels Before / After Meal*
	Breakfast:		/
	Snack:		/
	Lunch:		/
	Snack:		/
	Dinner:		/
	Snack:		/

*Use the Hunger Scale below to rank your hunger before and after meals

1	2	3	4	5	6	7	8	9	10
Starving, can't concentrate, dizzy	Extremely hungry, irritable	Very hungry	Hungry, ready to eat	Just noticing the first signs of hunger	Comfortable, satisfied	Feel you have eaten just a little bit too much	Uncomfortably full	Very uncomfortable, tired	Stuffed to the point of feeling sick (Thanksgiving full!)

Food consumed on a typical weekend day

Time	Food / Beverage Consumed	Amount Eaten	Hunger levels Before / After Meal*
	Breakfast:		/
	Snack:		/
	Lunch:		/
	Snack:		/
	Dinner:		/
	Snack:		/

*Use the Hunger Scale below to rank your hunger before and after meals

1 Starving, can't concentrate, dizzy	2 Extremely hungry, irritable	3 Very hungry	4 Hungry, ready to eat	5 Just noticing the first signs of hunger	6 Comfortable, satisfied	7 Feel you have eaten just a little bit too much	8 Uncomfortably full	9 Very uncomfortable, tired	10 Stuffed to the point of feeling sick (Thanksgiving full!)

Food Frequency List

Please list items in each group consumed on a regular basis. Please indicate the number of times you eat these foods in a typical week. Please indicate organic items in food groups marked with an *asterisk.

Foods			Number of times per week consumed:
Vegetables*:			
Do you consume fresh vegetable juice?	Yes	No	
Fruit*:			
Do you consume dried fruit?	Yes	No	
Do you consume canned or jarred fruit?	Yes	No	
Dairy and dairy alternatives*:			
Lunch/deli meat*: (including Lunchables®, bologna, salami, etc.)			
Fish: If you typically consume fish, is it typically fresh, fried or canned?			
Eggs: If you typically consume eggs, do you consume the whole egg or egg white?			
Vegetarian food products:			
Beans, legumes, peas:			
Nuts, nut butters and seeds:			
Protein drinks or powders:			
Please place any grain products you consume into the categories below:			
Bread, pasta, rice			
Muffins, donuts, sweet rolls, granola bars			
Pretzels, crackers			
Cereals (cold and hot)			

Foods	Number of times per week consumed:
Candy and sweets:	
Sugar and other sweeteners:	
Gum or breath mints: Do you chew regular gum or sugar free gum?	
Gluten free products;	
Please circle any prepared meals regularly consumed. : Weight Watchers®, Lean Cuisine®, Healthy Choice®, Mexican cuisine, Indian cuisine, Chinese/Thai, Vegetarian, Atkins®, Low carb, SlimFast®, Other:	
Other frequently consumed foods:	
Please place any beverages you consume into the categories below:	
Soda	
Juice	
Tea • Regular or decaffeinated? • How many 8 ounce cups per day?	
Coffee • Regular or decaffeinated? • How many 8 ounce cups per day? • Please list any other caffeinated beverages in your diet:	
Alcohol	
Water • How many 8 ounce cups per day? • What type of water do you consume? Filtered tap Spring water Distilled Other: • Do you drink bottled water? ○ If yes, please indicate how many ounces per bottle and how many bottles are consumed:	

86. What percentage of your total food intake is organic?

87. How many times a week do you go out to eat?

88. Rate the type of restaurants you frequent in order of most often to least often (1 being the kind you eat at most often, and 5 for the least often (or never).

Fast food	Casual dining
Fine dining	Breakfast diner
Café	Deli
Coffee shop	Other:

89. Where do you do most of your grocery shopping?

90. Who is the primary cook for the household?

91. On a scale of one through five, how much do you enjoy cooking?

1____5

I love cooking! I hate cooking!

92. What do you think might lie at the root of your health issues?

93. What do you need in order to heal?

94. 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 not give my registered dietitian at Balance Nutrition, LLC permissions to speak with and disclose my protected health information with the above named treatment providers.**

Signature: ______________________________ Date: ______________________________

Printed name: ______________________________

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