Client Information

Name:_______________________Date: __________

Beyond Broccoli Cancellation Policy

A minimum of 24 hours notice is required for cancellation of a Beyond Broccoli nutrition consultation otherwise payment will be expected for the missed visit.

Payment for all consults is expected at the time of service in cash or check form and a receipt is provided for all payments that may be submitted to insurance for reimbursement in accordance with your health care plan.

Hourly rates are $175 for individual consults unless prior arrangements are made for an adjusted rate to accommodate financial difficulties.

I have read and accept the terms of the Beyond Broccoli cancellation policy and rates for service. _______ (please initial)

How did you hear about Beyond Broccoli?

Referred by:

Would you like to give permission for an information exchange with another health care provider? Yes No

If yes, name and contact information for each provider:

Note: permission will expire within one year of the date on this form.

Reason for initial visit:

Long-term Goal(s):

Personal/contact Information

Information necessary for insurance claims:
Date of Birth: **Insurance provider:**
Policy #: **Group #:**
Name & address of policy holder:

Mailing address:

Email address:

Phone Number(s): (h) (w) (c)

Age: Date of Birth: Height: Weight:

Medical History

Current Medications (include over-the-counter and prescriptions – name and dosage):

Dietary Supplements Used (include vitamins, minerals, herbs, sports aids, etc.):

Known Abnormal Lab Values (cholesterol, blood pressure, etc.):

Medical Issues (past/present):

- Surgeries
- Medical diagnoses
- Family medical history of concern
- Circle any current symptoms:

Diarrhea	Night sweats
Constipation	Indigestion/heartburn
Excessive gas	Appetite changes
Bloating	Food cravings
Cramping/stomach pain	Dizziness
Nausea	Other ____________

Lifestyle/Habits

Occupation:

Living Situation (alone, with family, etc.):

Tobacco consumption (type/amount used per day):

Water Consumption per day (cups per day; 1 cup = 8 ounces):

- Other Fluids (daily):
- Caffeine intake (daily):
- Alcohol consumption (weekly):

Weekly physical Activity (include any physical activity in your daily life such as work, gardening, housecleaning as well as any intentional exercise such as sports, dance, yoga, gym):

Times per week:
Intensity (high/moderate/low):
Amount of time spent on each activity:

Eat away from home (meals or snacks per week):

Hours of sleep per night (average): Do you feel rested upon waking from sleep?

Stress – rate current stress:

1 None	2	3	4	5	6	7	8	9	10 Extreme

What do you do to manage your stress?

(Information below to be completed with dietitian unless this is a pre-visit form.)

Diet/Weight History
Please note any past or present issues related to diet/food/weight. Examples – history of dieting, disordered eating or an eating disorder, weight gain or loss, negative body image, or any other issues related to food or exercise that you think are important.

Do you have any food allergies or intolerances? If so please describe.

Do you think you have a healthy relationship with food?

Daily Food and Beverage Intake (use back of form or additional page if needed):
**Note: it is common to have different patterns for work or non-work days. Feel free to note these differences in the right hand column.*

Time	Food/Beverage Type	Amount	Notes