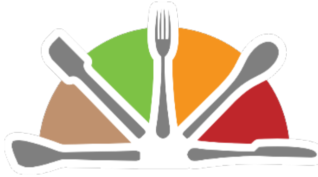

PO Box 79, Bergton, VA 22811
540-560-9232 (cell) 844-387-5221 (fax)
Email: kay@healthyweightoptionsllc.com
Website: www.healthyweightoptionsllc.com

NEW PATIENT INFORMATION FORM

Today's date ____________________________

Name ____

Address ____

Date of birth ____________________________ **Home phone #**____

Cell phone # ____ **May I text you updates (Yes/No)?** ________

Email address ____

If this is a referral (Yes/No)? __________ **If "yes," who referred you?** ______________________________

____

May I exchange information with your PCP or other medical practitioner (Yes/No)? __________________

If "yes," please provide the name and address of your PCP or other medical practitioner _______________

____

==

HEALTH INSURANCE INFORMATION

Name and address of your medical insurance company ____

____

Policy/ID # ____ **Group #** ____________________________________

Policy Holder's Name ____

Policy Holder's Birthday ______________________ **Relationship to Patient** ____________________________

May I exchange medical information with your medical insurance company for billing purposes?

(Yes/No) ___________

If you have a secondary medical insurance policy, please provide that information below. Otherwise, leave blank.

Name and address of your secondary medical insurance company ___________________________________

____

Policy/ID # ____ **Group #** ___________________________________

Policy Holder's Name ____

Policy Holder's Birthday ________________________ **Relationship to Patient** _________________________

May I exchange medical information with your secondary medical insurance company for billing purposes? (Yes/No) ________________

Note: *If I am in-network with your insurance provider, you will most likely have no out-of-pocket costs. If I am out-of-network with your insurance provider, you may have co-pays and/or deductibles. If you are uninsured, payment is due at the time of service, unless other arrangements are made in advance.*

===

ABOUT YOU

Age _______________ **Height** _______________**Weight** ______________ **Gender** _________________________

How physically active are you?

☐ Sedentary ☐ Lightly Active ☐ Moderately Active ☐ Very Active ☐ Don't know / Rather not say

Why do you seek nutrition counseling? ____

____

What are your nutrition and health-related goals? ____

____

Please list any prescription and over-the-counter medications you take regularly

____

____

Please list any herbal supplements, including diet aids, that you take regularly

____

____

Do you have any of the following health conditions?

- ☐ Hypertension/high blood pressure
- ☐ Prediabetes
- ☐ High Cholesterol
- ☐ Anorexia Nervosa
- ☐ Bulimia
- ☐ Constipation
- ☐ Celiac Disease
- ☐ Osteoporosis or Osteopenia
- ☐ Hyperthyroidism
- ☐ Irritable Bowel Syndrome
- ☐ Congestive Heart Failure
- ☐ Food Allergies (please list below)
- ☐ Hypotension/low blood pressure
- ☐ Diabetes
- ☐ High Triglycerides
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Arthritis
- ☐ Gluten Sensitivity
- ☐ Menopause
- ☐ Hypothyroidism
- ☐ Crohn's Disease
- ☐ Autoimmune Disease (MS, LUPUS, Hashimoto's, etc.)
- ☐ ME/CFS or Long-COVID

Please provide details of medical conditions checked above, and list any additional medical conditions

____

____

Are you currently on a special diet (Yes/No)? __________ **If "yes," please provide details** ____________

____

Are you or have you been on any special diets for weight control (Yes/No)? __________ **If "yes," please list**____

Number of adults in your home _________ **Number of children** _______ **Do you cook (Yes/No)?** _______

Ages of people living in your home ____

Do you have any religious or cultural food restrictions (Yes/No)? ______________

If "Yes," please describe ____

Do you engage in structured exercise (walking, weightlifting, yoga, etc.) (Yes/No)? __________ **If "yes," what do you do and how often?** ____

____

Please use the space below to write anything else you would like to share with me prior to our first session

____

____

PRIVACY INFORMATION

Please indicate below that you have access to my HIPPA policy.

"I received a copy of or access to Kay S Beatty MS, RDN's HIPPA policy and understand her privacy practices."

Name and Date ____

PATIENT'S DECLARATION

I have completed this form honestly and to the best of my knowledge. If my medical or insurance information changes, I will notify Kay S Beatty, MS, RDN of the changes, while I am under her care.

Patient's Signature* ____

Patient's Name, printed ____

Representative's Signature*, if applicable __________________________________

Representative's Name, printed, if applicable _______________________________

Date _________________________

*If you are completing this form online, your typed name is your signature.

I look forward to helping you feel your best! Kay S Beatty, MS, RDN