fort collins weight loss & nutrition
2620 E. Prospect Rd. Suite 160
Ft. Collins CO 80525

PATIENT INFORMATION FORM

Appointment Date ____/____/_____

_____ _____ _____ _____
FIRST NAME | MIDDLE NAME | LAST NAME | E-MAIL ADDRESS

_____ _____ _____ _____
STREET ADDRESS | CITY | STATE | ZIP CODE

(_____) _____-_____ (_____) _____-_____ (_____) _____-_____
HOME | CELL | WORK/OTHER

_____/_____/_____ _____ M F Married Single Partner _____'_____"
DATE OF BIRTH | AGE | SEX - CIRCLE ONE | MARITAL STATUS - CIRCLE ONE | HEIGHT

_____
SOCIAL SECURITY NUMBER (SSN) (FOR INSURANCE BILLING PURPOSES)

_____
EMERGENCY CONTACT

Parent or legal guardian information - if patient is under 18

_____ _____ _____ (_____) _____-_____
FIRST NAME | MIDDLE NAME | LAST NAME

_____ _____ _____ _____
STREET ADDRESS | CITY | STATE | ZIP CODE

HOW DID YOU HEAR ABOUT OUR PRACTICE? _____

Please INITIAL and SIGN the following statements:

_____ I consent to **Ft. Collins Weight Loss & Nutrition**'s use & disclosure of my Protected Health Information to carry out treatment, payment & health care operations.

_____ I acknowledge that the Privacy Practices of **Ft. Collins Weight Loss & Nutrition** was made available for my review *(page 5)*.

_____ I have reviewed the Financial Policy and agree to abide by the guidelines set forth therein *(page 5)*.

_____ I give my permission to release all of my medical-related information to the following person(s):

_____ _____ _____ _____
FIRST NAME | MIDDLE INITIAL | LAST NAME | RELATIONSHIP

_____ _____ _____ _____
FIRST NAME | MIDDLE INITIAL | LAST NAME | RELATIONSHIP

_____ _____ _____ _____
FIRST NAME | MIDDLE INITIAL | LAST NAME | RELATIONSHIP

_____ _____ _____ _____
FIRST NAME | MIDDLE INITIAL | LAST NAME | RELATIONSHIP

_____ I DO / DO NOT (circle one) give my permission to **Ft. Collins Weight Loss & Nutrition** to leave detailed information regarding my medical care at the following phone number: (_____) _____-_____

_____ _____/_____/_____
SIGNATURE | DATE

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HEALTH HISTORY FORM

NAME _____ ___/___/_____ DATE

PREGNANT? YES / NO (CIRCLE ONE) PLANNING A PREGNANCY? YES / NO (CIRCLE ONE)

REASON(S) FOR VISIT — DATE IT BEGAN

_____ ___/___/_____

_____ ___/___/_____

_____ ___/___/_____

LIST CURRENT HEALTH PROBLEMS FOR WHICH YOU ARE BEING TREATED:

_____

_____

_____

_____

WHAT TYPES OF THERAPIES HAVE YOU TRIED FOR THESE PROBLEM(S) OR TO IMPROVE YOUR HEALTH OVERALL?

☐ DIET MODIFICATIONS ☐ FASTING ☐ VITAMINS/MINERALS ☐ HERBS ☐ HOMEOPATHY ☐ CHIROPRACTIC ☐ ACUPUNCTURE ☐ CONVENTIONAL DRUGS

OTHER: _____

CURRENT MEDICATIONS - PRESCRIBED OR OVER-THE-COUNTER: _____

_____

CURRENT SUPPLEMENTS: _____

_____

LABORATORY PROCEDURES DONE (E.G. BLOOD/URINARY CHEMISTRIES, STOOL/HAIR ANALYSIS...): _____

_____

OUTCOME(S): _____

_____

MAJOR HOSPITALIZATIONS, SURGERIES, INJURIES - PLEASE LIST ALL PROCEDURES, COMPLICATIONS (IF ANY) AND DATES:

SURGERY/ILLNESS/INJURY — DATE

_____ ___/___/_____

_____ ___/___/_____

_____ ___/___/_____

CIRCLE THE LEVEL OF STRESS YOU ARE EXPERIENCING ON A SCALE OF 1 TO 10 (1 BEING THE LOWEST): 1 2 3 4 5 6 7 8 9 10

IDENTIFY THE MAJOR CAUSES OF STRESS (E.G. CHANGES IN JOB, WORK, RESIDENCE OR FINANCIAL, LEGAL PROBLEMS...): _____

DO YOU CONSIDER YOURSELF: ☐ UNDERWEIGHT ☐ OVERWEIGHT ☐ JUST RIGHT YOUR WEIGHT TODAY: _____

HAVE YOU HAD AN UNINTENTIONAL WEIGHT LOSS OR GAIN OF 10 POUNDS OR MORE IN THE LAST THREE MONTHS? _____

IS YOUR JOB ASSOCIATED WITH HARMFUL CHEMICALS (E.G. PESTICIDES, RADIOACTIVITY, SOLVENTS...) OR HEALTH AND/OR LIFE THREATENING ACTIVITIES (E.G. FIREMAN...)?_____

IF YES, WHAT? _____

WHAT ARE YOUR CURRENT HEALTH GOALS? _____

_____

Your Medical History

- ☐ ARTHRITIS
- ☐ ALLERGIES/HAY FEVER
- ☐ ASTHMA
- ☐ ALCOHOLISM
- ☐ ALZHEIMER'S DISEASE
- ☐ AUTOIMMUNE DISEASE
- ☐ BLOOD PRESSURE PROBLEMS
- ☐ BRONCHITIS
- ☐ CANCER
- ☐ CHRONIC FATIGUE SYNDROME
- ☐ CARPAL TUNNEL SYNDROME
- ☐ CHOLESTEROL, ELEVATED
- ☐ CIRCULATORY PROBLEMS
- ☐ COLITIS
- ☐ DENTAL PROBLEMS
- ☐ DEPRESSION
- ☐ DIABETES
- ☐ DIVERTICULAR DISEASE
- ☐ DRUG ADDICTION
- ☐ EATING DISORDER
- ☐ EPILEPSY
- ☐ EMPYSIMA
- ☐ EYE, EAR, THROAT, NOSE PROBLEMS
- ☐ ENVIRONMENTAL SENSITIVITIES
- ☐ FIBROMYALGIA
- ☐ FOOD ALERGIES
- ☐ GASTROESOPHAGEAL REFLUX DISEASE
- ☐ GENETIC DISORDER
- ☐ GLAUCOMA
- ☐ GOUT
- ☐ HEART DISEASE
- ☐ INFECTION, CHRONIC
- ☐ INFLAMMATORY BOWEL DISEASE
- ☐ IRRITABLE BOWEL SYNDROME
- ☐ KIDNEY OR BLADER DISEASE
- ☐ LEARNING DISABILITIES
- ☐ LIVER OR GALL BLADER DISEASE (STONES)
- ☐ MENTAL ILLNESS
- ☐ MENTAL RETARDATION
- ☐ MIGRAINE HEADACHES
- ☐ NEUROLOGICAL PROBLEMS (PARKINSON'S, PARALYSIS...)
- ☐ SINUS PROBLEMS
- ☐ STROKE
- ☐ THYROID PROBLEMS
- ☐ OBESITY
- ☐ OSTEOPOROSES
- ☐ PNEUMONIA
- ☐ SEXUALLY TRANSMITTED DISEASE
- ☐ SEASONAL AFFECTIVE DISORDER
- ☐ SKIN PROBLEMS
- ☐ TUBERCULOSIS
- ☐ ULCER
- ☐ URINARY TRACT INFECTION
- ☐ VARICOSE VEINS
- ☐ OTHER: _____

_____

Medical (Men)

- ☐ BENIGN PROSTATIC HYPERPHASIA
- ☐ PROSTATE CANCER
- ☐ DECREASED SEX DRIVE
- ☐ INFERTILITY
- ☐ SEXUALLY TRANSMITTED DISEASE
- ☐ OTHER: _____

Medical (Women)

- ☐ MENSTRUAL IRREGULARITIES
- ☐ ENDOMETRIOSIS
- ☐ INFERTILITY
- ☐ FIBROCYSTIC BREASTS
- ☐ FIBROIDS/OVARIAN CYSTS
- ☐ PREMENSTRUAL SYNDROME (PMS)
- ☐ BREAST CANCER
- ☐ PELVIC INFLAMITORY DISEASE
- ☐ VAGINAL INFECTIONS
- ☐ DECREASE SEX DRIVE
- ☐ SEXUALLY TRANSMITTED DISEASE
- ☐ OTHER: _____

DATE OF LAST GYN EXAM:__/__/____

MAMMOGRAM: □ + □ -

PAP: □ + □ -

FORM OF BIRTH CONTROL: _____

NUMBER OF CHILDREN: _____

NUMBER OF PREGNANCIES: _____

NUMBER OF C-SECTIONS: _____

AGE OF FIRST MENSTRUATION: ____

DATE OF LAST MENSTRUATION: __/__/__

LENGTH OF CYCLE _____ DAYS

INTERVAL BETWEEN CYCLE ____ DAYS

RECENT CHANGE IN MENSTRUAL FLOW (HEAVIER, LARGE CLOTS, SCANTY...)?

_____

- ☐ SURGICAL MENOPAUSE
- ☐ MENOPAUSE

Family Health History (Parents/Siblings)

- ☐ ARTHRITIS
- ☐ ASTHMA
- ☐ ALCOHOLISM
- ☐ ALZHEIMER'S DISEASE
- ☐ CANCER
- ☐ DEPRESSION
- ☐ DIABETES
- ☐ DRUG ADDICTION
- ☐ EATING DISORDER
- ☐ GENETIC DISORDER
- ☐ GLAUCOMA
- ☐ HEART DISEASE
- ☐ INFERTILITY
- ☐ LEARNING DISABILITIES
- ☐ MENTAL ILLNESS
- ☐ MENTAL RETARDATION
- ☐ MIGRAINE HEADACHES
- ☐ NEUROLOGICAL PROBLEMS (PARKINSON'S, PARALYSIS...)
- ☐ OBESITY
- ☐ OSTEOPOROSES
- ☐ STROKE
- ☐ SUICIDE
- ☐ OTHER: _____

Health Habits

- ☐ TOBACCO

CIGARETTES A DAY: _____

CIGARS A DAY: _____

- ☐ ALCOHOL

WINE: _____ GLASSES A WEEK
BEER: _____ GLASSES A WEEK
LIQUOR: _____ GLASSES A WEEK

- ☐ CAFFEINE

COFFEE: _____ 6OZ CUPS A DAY
TEA: _____ 6OZ CUPS A DAY
SODA W/CAFFEINE: ____ CANS A DAY
OTHER: _____

_____

- ☐ WATER: _____ GLASSES A DAY

Exercise

- ☐ 5-7 DAYS PER WEEK
- ☐ 3-4 DAYS PER WEEK
- ☐ 1-2 DAYS PER WEEK

Duration Per Workout

- ☐ 45 MINUTES OR MORE
- ☐ 30-45 MINUTES
- ☐ LESS THAN 30 MINUTES

Type of Workout

- ☐ WALK _____ DAYS A WEEK
- ☐ RUN/JOG/AEROBICS ___ DAYS A WEEK
- ☐ WEIGHT LIFTING ___ DAYS A WEEK
- ☐ STRETCH _____ DAYS A WEEK
- ☐ OTHER: _____

Nutrition & Diet

- ☐ MIXED FOOD DIET (ANIMAL & VEGETABLE)
- ☐ VEGETARIAN
- ☐ VEGAN
- ☐ SALT RESTRICTION
- ☐ FAT RESTRICTION
- ☐ STARCH/CARBOHYDRATE RESTRICTION
- ☐ THE ZONE DIET
- ☐ TOTAL CALORIE RESTRICTIONS
- ☐ SPECIFIC FOOD RESTRICTIONS
  □ DAIRY □ WHEAT □ EGG □ SOY
  □ CORN □ ALL GLUTEN
  □ OTHER: _____

Eating Habits

- ☐ SKIP _____ (MEAL)
- ☐ 1 MEAL A DAY
- ☐ 2 MEALS A DAY
- ☐ 3 MEALS A DAY
- ☐ GRAZE (SMALL FREQUENT MEALS)
- ☐ GENERALLY EAT ON THE RUN
- ☐ EAT CONSISTENTLY - HUNGRY OR NOT

I WOULD LIKE TO:

Energy-Vitality

- ☐ FEEL MORE VITAL
- ☐ HAVE MORE ENERGY
- ☐ HAVE MORE ENDURANCE
- ☐ BE LESS TIRED AFTER LUNCH
- ☐ SLEEP BETTER
- ☐ BE FREE OF PAIN
- ☐ GET LESS COLDS AND FLUS
- ☐ GET RID OF ALLERGIES
- ☐ NOT BE DEPENDANT ON OVER THE COUNTER MEDICATIONS LIKE ASPIRIN, IBUPROFEN, ANTI-HISTAMINES, SLEEP-AIDS, ETC.
- ☐ STOP USING LAXATIVES/STOOL SOFTENERS
- ☐ IMPROVE SEX DRIVE

Body Composition

- ☐ LOSE WEIGHT
- ☐ BURN MORE BODY FAT
- ☐ BE STRONGER
- ☐ HAVE BETTER MUSCLE TONE

Stress - Mental/Emotional

- ☐ LEARN HOW TO REDUCE STRESS
- ☐ THINK MORE CLEARLY & BE MORE FOCUSED
- ☐ IMPROVE MEMORY
- ☐ BE LESS DEPRESSED
- ☐ BE LESS MOODY
- ☐ BE LESS INDECISIVE
- ☐ FEEL MORE MOTIVATED

Life Enrichment

- ☐ REDUCE MY RISK OF DEGENERATIVE DISEASE
- ☐ SLOW DOWN ACCELERATED AGING
- ☐ MAINTAIN A HEALTHIER LIFE LONGER
- ☐ CHANGE FROM A TREATING ILLNESS ORIENTATION TO A CREATING WELLNESS LIFESTYLE

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FOOD/EXERCISE LOG

Please complete one or more day(s).

This is simply data about your current nutrition. Be as detailed as possible, but don't worry if it is imperfect.

Time ***Specifics:***

Woke Up:

____:____

Morning Meal:

____:____

Morning Snack:

____:____

Mid-day Meal:

____:____

Afternoon Snack:

____:____

Evening Meal:

____:____

Evening Snack:

____:____

Water: Other Drinks:

IN OUNCES IF NOT LISTED WITH MEALS ABOVE

Activity/Exercise:

____:____ ____:____ TYPE
BEGAN ENDED

____:____ ____:____ TYPE
BEGAN ENDED

____:____ ____:____ TYPE
BEGAN ENDED

Relaxation:

____:____ ____:____ TYPE
BEGAN ENDED

____:____ ____:____ TYPE
BEGAN ENDED

Went to sleep:

____:____

Missed Appointments

At least 24 hours advance notice is required for appointment changes. Failing to cancel within the allotted time will result in a $65 fee. Please help us serve you better by keeping scheduled appointments.

"I hereby agree to the above stated terms and conditions"

_____ SIGNATURE

____/____/____ DATE

Patients with no insurance cards

If you cannot provide **Ft. Collins Weight Loss & Nutrition** with all the billing information necessary to file your claim, we will ask you to pay in full at the time of service. Once you are able to provide all billing information, we will bill your insurance (if we are contracted) and refund your payment after we are paid by your insurance company.

"I hereby agree to pay **Ft. Collins Weight Loss & Nutrition** in full at the time of service and agree to the above stated terms and conditions."

_____ SIGNATURE

____/____/____ DATE

Payment default

In the event that I default on payment of my account, I understand I am responsible for any and all cost incurred on the collection of my account, including court cost and reasonable attorney's fees. If the debt is assigned to a third party collection agency, I agree to be responsible for collection fees and interest due to amounts in default.

I hereby agree to the above stated terms and conditions"

_____ SIGNATURE

____/____/____ DATE

Patients with out-of-network insurance coverage, high deductible insurance plans or no insurance

Ft. Collins Weight Loss & Nutrition offers a sliding scale of $65 per hour with Kayla Thorngate, RDN. A credit card number is required when booking the appointment and will be charged at the end of the appointment. If you miss a scheduled appointment and fail to provide 24-hour advance notice, you will be charged $65.

"I hereby agree to the above stated terms and conditions"

_____ SIGNATURE

____/____/____ DATE

Patients with in-network insurance coverage

Payment of any co-pays, is required at the time of service. You must present your insurance card at each office visit. You are responsible for knowing your own insurance benefits such as if your deductible has been met. If your insurance company does not pay a portion of the visit, you will be responsible for the remaining balance when we mail you an invoice. Rates are billed per 15 minute increments, $30.02 for initial visit and $26.02 for subsequent visit.

"I hereby authorize **Ft. Collins Weight Loss & Nutrition** to bill insurance on my behalf and agree to the above stated terms and conditions."

_____ SIGNATURE

____/____/____ DATE

NOTE: Once insurance is billed and monies go towards a deductible, the full amount assigned to deductible will be collected. Subsequent visits can be billed differently.

PRIVACY POLICY:

Ft. Collins Weight Loss & Nutrition will not share your protected health information with anyone outside the office without written permission. Office staff that has access to your information includes the registered dietitians, medical billers and financial accountant.