Patient Information

Patient Information

First:_____ Middle:_____ Last Name_____

Nickname: (if applicable) _____ Date of Birth: _____ o Male o Female

Social Security #: _____Marital Status: Single Married Separated Divorced Widow Other

Mailing Address:_____

City: _____ State: _____ Zip Code: _____

Employer: _____ Preferred Method of Contact: Phone Email Mail

Cell Phone: _____ Home Phone _____Work Phone_____

Email Address: _____

Emergency Contact

Name: _____ Phone: _____ Relationship: _____

Insurance Information

Insurance Carrier: _____ ID #: _____

Group #: _____ Policy Holder's Name: _____

Policy Holder's Date of Birth: _____ Relationship to patient: _____

Primary Care Physician

Name _____ Phone _____ Fax _____

Address _____ City _____ State _____ Zip _____

Name of Referring Medical Professional (If applicable)

Name _____ Phone _____ Fax _____

Address _____ City _____ State _____ Zip _____

Patient/Guarantor Signature Date

_____

Printed Name and Relationship to Patient

Consent for Use or Disclosure of Protected Health Information for Payment, Treatment and Health Care Operations

By signing below, you hereby consent for this Practice to use or disclose information about yourself (or another person for whom you have the authority to sign) that is protected under federal law, for the sole purposes of treatment, payment and health care operations. You may refuse to sign this consent form.

You should read the Notice of Privacy Practices for PHI attached to this form before signing the Consent. The terms of the Notice may change from time to time, and you may always get a revised copy of it by asking the Privacy Officer for this Practice.

You have the right to request that the Practice restrict how PHI is used or disclosed to carry out treatment, payment, or health care operations. The Practice is not required to agree to requested restrictions, however; if the Practice agrees to your requested restrictions, the restriction is binding on it.

Information about you is protected under federal law, and you have the right to revoke this Consent, unless we have taken action in reliance on your authorization (as determined by our Privacy Officer). By signing below, you recognize that the protected health information used or disclosed pursuant to this Consent may be subject to re-disclosure by the recipient and may no longer be protected under federal law.

Please check the following if applicable:

- ☐ You may call my home and leave a message with someone or on an answering machine if I am not available.
- ☐ You may call my place of employment and leave a message on an answering machine or with someone if I am not available.
- ☐ You may call my cell phone and leave a message on my answering machine if I am not available.
- ☐ You may communicate confidential information to me, including invoices for services, to the address and/or phone numbers that is given in my patient information. If not, please indicate the address or phone number that we may use:

_____

- ☐ You may discuss by email or phone, my child's symptoms (if pediatric patient), diagnosis and treatment with teachers and school representatives.
- ☐ I agree to use email communication for medication management including discussion of symptoms/side effects. I realize that email is not completely private and is permanent.
- ☐ I authorize Carolina Functional to release my medical records to the referring provider
- ☐ I consent to disclosure of the following protected health information about me to the following family member(s) or person(s) involved in my care or payment for care:

Name: _____ Relationship: _____
Name: _____ Relationship: _____
Name: _____ Relationship: _____
Name: _____ Relationship: _____

Check all that apply to names above:

- ☐ All my medical information
- ☐ Information necessary to schedule appointments for me
- ☐ Lab or test results
- ☐ Information necessary to help my family member(s) take care of me
- ☐ Information necessary to bill for or submit claims for care provided to me to government or private insurance payers

☐ I authorize Carolina Functional Nutrition to correspond with my Primary Care Physician.
☐ I acknowledge by signing below that I have received the Notice of Privacy Practices and Notice of Individual Rights.

Patient Name: _____ Patient Date of Birth: _____/_____/_____

Signature: _____ Date: _____/_____/_____

Relationship to Patient: □ Parent □ Guardian □ Self

Informed Consent Form &
Terms For Nutritional Counseling

I am employing the nutrition counseling services of Rhya Pachin, RDN, LDN at PETRO FITNESS, LLC in order to obtain information and guidance about health factors within my own control (diet, nutrition, and related behaviors) in order to nourish and support my health and wellness.

I understand that Rhya Pachin is a Registered Dietitian/Nutritionist at PETRO FITNESS, LLC and does not dispense medical advice nor prescribe treatment. Rather, she provides education to enhance my knowledge of health as it relates to foods, dietary supplements, and behaviors associated with eating. While nutritional and botanical support can be an important compliment to my medical care, I understand nutrition counseling is not a substitute for the diagnosis, treatment, or care of disease by a medical provider.

Nutritional evaluation or testing provided in counseling is not intended for the diagnosis of disease. Rather, these assessment tests are intended as a guide to developing an appropriate health-supportive program for me, and to monitor my progress in achieving my goals.

I understand that Rhya Pachin, RDN, LDN and PETRO FITNESS, LLC will keep therapy notes as a record of our work together. These notes document the topics that we talk about, interventions used, and treatment plan or any other considerations that may be helpful to your work with me. Records will be stored in a secure location. Medical records, personal information and history divulged in session to Rhya Pachin, RDN, LDN and PETRO FITNESS, LLC will be kept strictly confidential unless I consent to sharing my medical and nutritional information by way of a signed release.

I acknowledge that I have read and understand the HIPAA privacy agreement provided in hard copy form from Rhya Pachin, RDN, LDN at PETRO FITNESS, LLC. I agree to hold Rhya Pachin, RDN, LDN, PETRO FITNESS, LLC, their principals, agents, employees, and volunteers harmless for claims or damages in connection with our work together. This is a contract between myself and Rhya Pachin, RDN, LDN of PETRO FITNESS, LLC and I understand that it is also a release of potential liability.

I understand that Rhya Pachin, RDN, LDN has a 24-hour cancellation policy, and I am aware that I will be charged a follow up fee ($75.00) for a missed appointment if proper notice is not given (by phone or email). This same integrity is in effect for Rhya Pachin, RDN, LDN. Should she ever have to cancel within 24 hours of the appointment, your next follow up appointment is free. Payment is required at the time of service. Cash, check and major credit cards are accepted.

Nutrition counseling services may be terminated at the discretion of Rhya Pachin, RDN, LDN of PETRO FITNESS, LLC if written notification is provided to a client 30 days in advance of final appointment. This will include a listing of referrals for continuity of care.

_____ _____

Client or Guardian's Signature Date

_____

Print Name

Patient Name: _____ Date of Birth: ___/___/_____Date: ____/____/____

Nutrition Intake Form

1. Name of person completing this form: _____

Relationship to patient: _____

2. Chief Complaints:

_____
_____
_____

3. Medical/Surgical History (ALL current and past medical diagnoses, past surgeries):

_____
_____
_____
_____

4. List ALL current medications, supplements, vitamins and dosages for each:

Name: _____ Dose: _____
Name: _____ Dose: _____
Name: _____ Dose: _____
Name: _____ Dose: _____
Name: _____ Dose: _____
Name: _____ Dose: _____
Name: _____ Dose: _____
Name: _____ Dose: _____

5. Does the patient have any allergies? (drug, food, seasonal, environmental) ☐ Yes ☐ No
If yes, please name and describe the reaction: _____

_____

6. Are there any foods that "don't agree" with the patient?

_____
_____
_____

7. Eating Habits/Lifestyle Considerations:

- What is your occupation? _____
- How often do you cook from scratch? _____
- How often do you eat out? _____
- Do you tend to skip meals? ☐ Yes ☐ No
- Do you ever eat for comfort? ☐ Yes ☐ No
- What situations cause you to eat for comfort?

  _____
  _____
- What areas of your life do your health problems interfere with?_____

  _____
- What foods (if any) do you crave?

  _____
  _____
- Is there any food you could not give up for 2 weeks?

  _____
  _____
- On a scale of 1-10, how badly are these problems affecting your life? _____
- On a scale of 1-10, how committed are you to getting better? _____

Initial Symptoms Survey

Patient Name: | **Practitioner:**

Instructions: ***Score <u>every</u> symptom based on your experience OVER THE PAST MONTH***. Using the SCALE OF SYMPTOM POINTS listed below, FILL IN the appropriate score to the left of EVERY symptom listed. Write the "Grand Total" at the top. Also note the number of missed work days you have had in the last month due to illness.

Scale of Symptom Points: If you did not suffer from the symptom ever or almost never, leave it blank.

1 = Occasionally (less than 2 times per week) and symptom was MILD
2 = Frequently (2 or more times per week) and symptom was MILD
3 = Occasionally (less than 2 times per week) and symptom was SEVERE
4 = Frequently (2 or more times per week) and symptom was SEVERE

Grand Total:

 # Missed work days:

Constitutional		**Nasal/Sinus**		**Musculoskeletal**	
	Fatigue (sluggish, tired)		Post Nasal Drip		Joint pains
	Hyperactive (nervous energy)		Sinus Pain		Stiff joints
	Restless (can't relax/sit still)		Runny Nose		Muscle aches
	Daytime sleepiness		Stuffy Nose		Stiff muscles
	Insomnia at night		Sneezing		Tics (facial or otherwise)
	Malaise (feeling lousy)		Total (0-20)		Muscle spasms
	Seizures	**Mouth/Throat**			Muscles cramps
	Total (0-28)		Sore throat		Total (0-28)
Emotional/Mental			Swollen throat	**Cardiovascular**	
	Depression		Swelling/burning lips/tongue		Irregular heartbeat
	Anxiety (fears, uneasiness)		Gagging/throat clearing		High blood pressure
	Mood swings (rapid changes)		Canker sores		Total (0-8)
	Irritability		Difficulty swallowing	**Digestive**	
	Forgetfulness		Total (0-24)		Heartburn/reflux
	Lack of concentration/brain fog	**Lungs**			Stomach pains/cramps
	Low sex drive		Wheezing		Intestinal pains/cramps
	Total (0-28)		Chest congestion		Constipation
Head/Ears			Dry cough		Diarrhea
	Headache (not migraine)		Wet cough		Bloating sensation
	Migraine		Shortness of breath		Gas (of any kind)
	Earache		Total (0-20)		Nausea
	Ear infection	**Eyes**			Vomiting
	Ringing in ears		Red or swollen eyes		Painful elimination
	Itchy ears		Watery eyes		Total (0-40)
	Discharge from ears		Itchy eyes	**Weight Management**	
	Sensitivity to sound		Dark circles or "bags"	Current Weight:	
	Total (0-32)		Sensitivity to light		Fluctuating weight
Skin			Aura		Food cravings
	Blemishes, acne		Total (0-24)		Water retention
	Rashes or hives	**Genitourinary**			Binge eating or drinking
	Eczema or psoriasis		Increased urinary frequency		Purging (all methods)
	"Rosy" cheeks		Painful urination		Total (0-20)
	Flushing		Bladder pain	**List Other Symptoms**	
	Itchy skin		Bedwetting		
	Total (0-24)		Total (0-16)		