E.L.M. WELLNESS
CLIENT REGISTRATION FORM

CLIENT's NAME: _____ DATE: _____

HOME ADDRESS: _____

City: _____ State: _____ Zip Code:_____

PHONE NUMBERS:
Can a confidential message be left at these numbers?
Home: Yes No Home#_____

Cell: Yes No Cell# _____

Work: Yes No Work# _____

EMAIL:_____

Yes No Acceptable to contact me by e-mail
Yes No Acceptable to contact my health professionals by e-mail, without my name Disclosed (using initials or a code)

Note: E-mail contact is for your benefit only. Information is not shared without additional consent from you. The E.L.M. Wellness outgoing email is HIPAA compliant.

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REFERRED BY or How did you hear of E.L.M. Wellness?:_____

_____

REASON FOR REFERRAL: _____

_____

****

PERSON RESPONSIBLE FOR PAYMENT (if not client):

_____

ADDRESS if Different: _____

City: _____ State: _____ Zip Code: _____

PHONE NUMBERS:
Can a confidential message be left at these numbers? Please circle:
Yes No Home#_____

Yes No Cell# _____

Yes No Work# _____

EMAIL:_____

Yes No Acceptable to contact me by e-mail
Yes No Acceptable to contact my health professionals by e-mail, without my full name disclosed

Note: E-mail contact is for your benefit only. Information is not shared without additional consent from you. The E.L.M. Wellness outgoing email is HIPAA compliant.

E.L.M. WELLNESS
CLIENT MEDICAL HISTORY FORM

CLIENT's NAME:_____ DATE: _____

DATE OF BIRTH: _____ AGE: _____ HEIGHT (without shoes) _____

GENDER: F M Transgender: FtM MtF Preferred pronoun: _____

REASON FOR THE VISIT or Diagnosis? _____

EMPLOYER/SCHOOL: _____

OCCUPATION(s): _____

MARITAL STATUS: (circle) Single Married Engaged Separated Divorced Widowed

Spiritual Affiliation: _____

Living with whom? _____

Do you have children, if yes, what are their ages? _____

Pets? Type/name: _____

MEDICAL CONDITIONS: (Please Circle or list below all that apply)

Allergies food: _____
Anemia – iron or folate
Amenorrhea (loss of menses)
Arthritis OA or RA
Cancer
Celiac Disease
Chronic Fatigue Syndrome
Diabetes I or Diabetes II
Insulin Resistance – Pre-Diabetes
Diverticulosis
Esophageal Reflux (GERD)
Eczema
Fibromyalgia
Gluten Intolerance
Heart Disease
Hiatal Hernia
High Cholesterol or LDL
High Triglycerides
High Blood Pressure
Hyperthyroidism
Hypothyroidism
Hypoglycemia
Irritable Bowel Syndrome
Irritable Bowel Disease
Kidney Stones
Lactose Intolerance
Migraines
Osteoporosis or Osteopenia
Polycystic Ovary Syndrome (PCOS)
Ulcers in Stomach or GI tract
Other _____

PSYCHOLOGICAL ISSUES:

Anorexia Nervosa
Bulimia Nervosa
Binge Eating Disorder
Compulsive Over Eating
Compulsive: Spending/Gambling/Sex
Other: _____
ADD or ADHD
Anxiety
Autism Spectrum disorder/Asperger's
Bipolar I
Bipolar II
Borderline Personality Disorder (BPD)
Depression
Obsessive Compulsive Disorder (OCD)
Substance abuse
Trauma/PTSD

Family Medical History: has anyone in your family had any of the following conditions?

	Cancer	Diabetes	Heart Disease	High Blood Pressure	High Cholesterol	Stroke	Obesity	Osteoporosis	Eating Disorder	Mental illness	Substance abuse
Mom											
Dad											
Daughter											
Son											
Sister											
Brother											
Ma GM											
Ma GF											
Ma Uncle											
Ma Aunt											
Pa GM											
Pa GF											
Pa Aunt											
Pa Uncle											

Name: _____

PAST HOSPITALIZATIONS, TREATMENT CENTERS OR SURGERIES? (use back of form if necessary)

Date	Procedure or Facility

CURRENT MEDICATIONS – (use back of form if necessary) Dose/Mg: Frequency:

VITAMINS/MINERALS and SUPPLEMENTS/HERBALS: Dose/Mg: Frequency:

Have you been experiencing any of the following in the last month? (please circle)

Nausea Vomiting Diarrhea Constipation Early satiety Bloating/gas Edema (water retention)

Headache Dizziness Fainting Chewing problems TMJ Teeth Grinding Intolerance to cold

Lack of concentration Reflux/GERD Night Sweats Other: _____

Bowel Movements: Frequency – per day: _____ per week: _____
(We are medical professionals, this provides diet and health information, please don't be shy.)
Consistency: Formed stools Soft Hard Balls Log shaped Straining at stool Diarrhea Hemorrhoids

Hours of sleep per night? _____
Sleep pattern: Solid sleep Difficulty Falling asleep Difficulty staying asleep Over sleeping

FOOD ALLERGIES or intolerances (Please List): use back of form if necessary.
If none please circle NONE

Food:	Reaction:	Life threating?

Vegetarian? NO YES – type: Ovo Lacto Pesco Pollo Vegan How long? _____

How did you come to this decision? _____

Do you ever eat/crave non-food items? N Y: ice dirt starch paper chalk other: _____

Do you chew gum? No Yes – how much/how often/how long? _____

Do you use tobacco products? No Yes - Frequency/amount: _____

Do you use marijuana or drugs? No Yes -What type(s): _____ How often? _____
(This information will be kept Confidential)

Do you drink alcohol? No Yes: Beer Wine Liquor Frequency/Amount per week? _____
History of alcohol abuse? No Yes

Weight (if known) _____where? _____ when? _____ by whom? _____

Weigh self? Y N Sometimes In past Frequency? _____ Where? _____

Highest Weight(not pregnant): _____ When/Scenario?_____

Lowest Weight: _____When/Scenario?_____

Usual or most frequent weight: _____ Scenario: _____

Name: _____ E.L.M. Wellness - Client Medical History page 3

Weight 1 year ago? _____ Weight 6 mos ago? _____ Weight 3 mos ago? _____

Do you count calories? N Y In past Some If so which ones? All _____

Do you weigh/measure food? N Y In past Some If so, which ones? _____

Food avoidances and why? _____

Food dislikes and why? _____

Any eating rituals? _____

Are you comfortable eating with others? Y N Sometimes Certain people Who? _____

Are you comfortable eating in restaurants? Y N Certain ones Which? _____

Do you eat differently when you are alone? Y N Sometimes How? _____

Do you feel physical hunger? Y N Sometimes
When? _____ How does it feel? _____

Can you tell the difference between physical and emotional hunger? Y N Sometimes

Does your eating change when you are under stress or extreme stress? N Y Sometimes How? _____

Do you restrict food intake or diet? N Y – Frequency? _____

Do you binge eat? N Y – Frequency? _____

Do you purge? N Y – Frequency and how? _____

Do you use diet aids/pills? N Y: type? _____ Frequency/Amount? _____

Do you use laxatives? N Y: type? _____ Frequency/Amount? _____

Do you use water pills/diuretics? N Y: type? _____ Frequency/Amount? _____

What percentage of time do you think about food, weight and exercise? _____%

How do you feel when you see your body? 1 2 3 4 5
Extreme dislike Neutral Extreme like

FEMALES/FtM: Date of last period: _____
(circle) Regular Never regular Irregular Spotting Normal flow Heavy flow Light flow

Weight at first period (if known): _____ Age: _____ Ht: _____

If you have lost your period at any time, at what weight did it stop? _____ return? _____

Bone Density Test: No Yes/Date: _____ Results: Normal Osteopenia Osteoporosis Unknown

EXERCISE PATTERN:
Type of exercise: Length of time: Number of days per week:

_____

_____

_____

Do you consider yourself a compulsive exerciser? Yes No Sometimes
Do your health/psychological providers? Yes No

COPING/RELAXATION SKILLS/THERAPY: (i.e. deep breathing, muscle relaxation, yoga, CBT, DBT, etc.)

Currently using: _____

Learned: _____

INTERESTS/HOBBIES:_____

SUPPORT SYSTEM: (with whom can you confide in?) _____

E.L.M. WELLNESS
(919) 656-3448

Authorization to Obtain and Release Confidential Information for the Purpose of Assessment and Future Treatment

I, **(Client name)** _____, **Date of Birth**: _____hereby authorize ELM Wellness to obtain and release information regarding past and current treatment from the following listed below. This information may include full health history, general and specific information regarding medical and psychological assessment/treatment and progress notes, laboratory tests, growth charts, special evaluations/testing, nutrition evaluation and counseling, school performance, social and emotional functioning, special learning problems or capabilities, educational testing, etc.

Please provide the contact information for your <u>current and/or past therapist, physician, psychiatrist, nutritionist, treatment center, coach, school/university personnel and any family members</u> with whom you choose to have ELM Wellness Dietitians communicate as part of your treatment team.

_____ _____

***Name/Title** Relationship

Address

City Zip code

Phone Number Fax Number

Email Website

***Name/Title** Relationship

Address

City Zip Code

Phone Number Fax Number

Email Website

_____ _____

***Name/Title** Relationship

Address

City Zip code

Phone Number Fax Number

Email Website

***Name/Title** Relationship

Address

City Zip Code

Phone Number Fax Number

Email Website

I understand that my records are confidential and will not be disclosed without my consent unless under legal compulsion or in life threatening situations. I also understand that I may revoke consent at any time, except to the extent that action has been taken in reliance therein. <u>Unless stated, this authorization remains in effect for one year after last session</u>.

_____ _____

Client Signature) Date

_____ _____

Parent/Guardian Signature if Client is under age 18 Date

_____ _____

Witness Date

E.L.M. WELLNESS
Phone: (919) 656-3448

Welcome, and thank you for allowing us the opportunity to help you meet your nutritional goals. The following information will provide you with some general information regarding our practice.

Schedule of Fees

Initial assessments are typically 80-minutes at a rate of $205.00. Follow-up sessions are 50 minutes at a rate of $120.00. Written reports requested by you or other health professionals or insurance companies are $50.00. Telephone consultations that are five minutes or less are complimentary, up to 15 minutes a rate of $30.00 will be applied, up to 30 minutes a rate of $60.00 will be applied, beyond 30 minutes the regular fee schedule will apply. Fees are subject to change with a 30-day in office and web site notice. Last fee change was on 6/1/13.

Appointments

24-hour notice of cancellation is respectfully required. You will be charged full fee for the missed appointment unless notice of cancellation is received 24 hours in advance of the scheduled time. Insurance companies do not pay for missed appointments. This fee is waived in the case of hospitalization or natural disasters. The fee for missed appointments is due within 7 days or at your next appointment, whichever comes first.

*As a courtesy to our other clients, if you have a contagious illness (cold, flu, etc.), you are encouraged to cancel the appointment within 24 hours and reschedule when you are well again.

If you are late to your appointment, the session will still end at the scheduled time. If the provider starts late, you will be given your full time.

For private pay clients, phone and video sessions are available for clients once a relationship has been established or during a natural disaster or inclement weather. It is the responsibility of the client to initiate the call for a phone/video session. For therapeutic reasons, your provider may decline a last minute request to change from an office visit to a phone/video session. Virtual sessions are available for those who are paying out of pocket for the session. At this time in NC, insurance does not cover virtual sessions.

Insurance Reimbursement/Payment

E.L.M. Wellness is a provider for some BCBSNC for most plans, with the exception of Blue Value, that include nutrition services. Insurance card and photo ID must be present at time of appointment. If payment is declined by the insurance company, the client is responsible for payment. For all other insurance companies, the client is asked to file for insurance reimbursement. Please contact your insurance company prior to your first appointment to obtain reimbursement details. Upon payment at each session, a claim submission form for insurance reimbursement will be provided.

Fees may be paid by cash, checks made payable to ELM Wellness or most major credit cards. Payment is due at the time of each appointment. If you have forgotten to bring payment, we will gladly reschedule your appointment. Questions about fees and payment should be discussed prior to or at the beginning of your appointment. Fees for phone sessions and missed appointments should be mailed to E.L.M. Wellness, 4917 Waters Edge Dr., #220-7, Raleigh, NC, 27606 or you may bring it to your next session if one is scheduled within the next 7 days. You may also call in credit card information, including number, expiration date, V-Code and billing address including zip code. Any fees incurred for returned checks or any other costs associated with collection of fees will be the responsibility of the client. A 10% late fee will be assessed monthly on any unpaid balance of 30 days or more.

Required: Credit Card information. This will only be used in case insurance does not cover your sessions or you fail to cancel an appointment within 24 hours. You will be notified prior to your card being charged.

Number: _____ Expiration Date: _____ V-Code _____

Client Acknowledgements: I am aware that the practice of medical nutrition therapy is not an exact science and I acknowledge that no guarantees have been made to me as to the results of nutrition counseling. I acknowledge that I am responsible for payment and 24 hour notice of cancellation.

I hereby acknowledge that I have read the above and all my questions have been answered to my full satisfaction. I also acknowledge responsibility for this account and assume and guarantee payments of all charges against this account as they accrue. I give E.L.M. Wellness permission to charge my listed credit card for outstanding balances and will provided updated card number or expirations dates, V-codes and zip codes as they change.

Signed: _____ Dated: _____

Client or Parent/Guardian if client is under age 18

ELMWellness.com
Phone: (919) 656-3448

Privacy Consent

We require your consent to use and disclose your protected health information to carry out treatment, payment, and health care operations. If you would like a more detailed description of such uses and disclosures, please refer to the *Notice of Privacy Practices*.

You have the right to review the *Notice of Privacy Practices* before signing this consent form. See website for details. The terms of the *Notice of Privacy Practices* may change from time to time. You can get a copy of the latest *Notice of Privacy Practices* by contacting our office. We also will post a copy of our current *Notice of Privacy Practices* in our office.

You have the right to request that we restrict how we use or disclose protected health information to carry out treatment, payment, or health care operations. We do not have to agree to such requests, but must honor the requests to which we can agree.

You have the right to revoke this consent in writing, and the revocation will become effective except to the extent that we acted in reliance on your consent.

By signing below, you hereby consent to our use of your protected health information to carryout out treatment, payment, and health care operations, and acknowledge receipt of a copy of this consent if requested.

Printed name: _____

Signature: _____ Date: _____

Confidentiality Statement

All information shared between the client and E.L.M. Wellness is confidential. Exceptions to this rule include:

1. If you request that information be released or shared as stated and signed in the "Release of Information/Consent Form."

2. If the dietitian believes that a client is a clear and imminent danger to self or others, the appropriate people will be contacted to prevent that occurrence.

3. If ordered by the courts and not subject to privilege.

4. To other medical/health practitioners of your choice for continuity of care.

5. To your insurance company, if requested, to process your nutrition claims.

In Public:

In order to protect your confidentiality, if you see your dietitian in public, an effort will NOT be made to acknowledge you. You do have the choice to acknowledge her/him. If you do, you take the risk of acknowledging that you are her/his client, which is protected health information.

ELM WELLNESS

3 Day Food Diary

Please list **all foods and beverages** consumed. **Please provide estimates of amounts**.
At the bottom of each day indicate what activities you participated in and the duration.

	Breakfast	Snack	Lunch	Snack	Dinner	Snack
SAMPLE	1 cup raisin bran	1 Kind bar	Tuna Salad, ¼ cup	Apple - Large	Salmon 3 oz. dill sauce	1 Lg bag Micro
	4 oz whole milk	2 Tbls creamer	Small brownie	1 T PB	Broccoli 1 cup plain	Popcorn Butter
	6 oz Orange juice				Baked potato w 1 T butter	flavor
	Banana - medium				1 cup salad w/ dressing	
	Fluids/alcohol:	12 oz. water, 8 oz. Decaf	12 oz. .Diet Coke	8 oz. Gatorade, 4 oz. H20	12 oz. Iced Tea sweetened	10 oz. Wine
	Activities: walked 20 minutes, Tennis lesson 1 hour					

DATE:____	Breakfast	Snack	Lunch	Snack	Dinner	Snack
	Beverages Alcohol					
	Activities:					

DATE:____	Breakfast	Snack	Lunch	Snack	Dinner	Snack
	Beverages Alcohol:					
	Activities:					

DATE:____	Breakfast	Snack	Lunch	Snack	Dinner	Snack
	Beverages Alcohol:					
	Activities:					