NATION'S BEST
FAMILY HEALTH CARE

Nutrition Background History and Consultation

NAME:	
DATE OF BIRTH:	
ADDRESS:	
CITY:	STATE:
PRIMARY PHONE: Cell or Home	SECONDARY PHONE: Cell or Home
E-MAIL ADDRESS:	
PLACE OF EMPLOYMENT/OCCUPATION:	

Program Overview

The NBFHC Nutrition program is designed based on Medicare guidelines to improve health and not only lose weight for those who are overweight, but reduce the need for medications for other conditions such as hypertension, high cholesterol, diabetes or joint pains. Your success in the program will depend on your willingness to make changes to improve your nutritional status and increase your activity levels.

The majority of the program is covered by most insurances and your normal copay per visit is also due at each visit. For those not wishing to use their insurance for the program, there are cash pay options available to you as well.

Your visits will be scheduled every 1-4 weeks depending on your progress, generally consisting of 8 visits over 3 months and 12 visits over 6 months with regular weight and vital signs checks at each visit.

Your medications may need to be adjusted during the program to compensate for the changes made in your body as your nutrition improves. You will continue to have scheduled appointments with your medical provider to discuss any medication changes needed during the program. Your nutritionist will have specific recommendations for foods and possibly supplements, but we are able to work with just about any type of diet and occupation.

We sincerely hope you enjoy your progression through the program.

YOU CAN. EXPECT MORE. FROM NATION'S BEST FAMILY HEALTH CARE.

1. In the past year, how often have you engaged in physical activity?
   - A. Regularly (3-4 times/week)
   - B. Semi regularly (1-2 times/week)
   - C. Sporadic (1 to 2 times/month)
   - D. None

2. Please explain your current exercise regime or activities performed in the past:

3. What is the primary reason for your visit today?

4. What is YOUR primary health concern/illness?

5. What have been your personal barriers for not exercising or following a nutrition program?

6. On a Typical day (MOST OFTEN) what time do you get up and go to bed (___to___)?

7. Facility where you exercise (home or gym) and how long have you been working out?

8. Rate your activity level:
   A. Not very active (go to work and little else)
   B. Moderately active (work and exercise 2-4 days during the week)
   C. Very active (work and at least 1 hour of exercise 5+ days/week)
   D. Competetive (compete in an physically intensive sport)

9. Weight Training Experience:
   A. Have you ever trained with weights before? If so, when, and for how long? What results did you get? Were you satisfied with the results?

   B. Are you currently following any exercise program? If so, what type (i.e. Aerobics, weight training, etc.) and for how long?

   C. Past Fitness Trainers Hired (If Any). Please list who, when, for how long and if you were satisfied with the results?

10. Are you currently on any special diet or nutrition program? Have you tried any specific diets or weight loss programs in the past?

11. What days and times are you available to exercise (at home or a facility)? (3 days minimum)

DAYS	***yes or no***	***TIMES***
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		
Saturday		
Sunday		

12. Alcohol consumption: (x per week, number of drinks and type)?

13. *Specifically* describe what you would like to accomplish overall (mentally and physically)?

14. *Specifically* describe what you would like to accomplish during the next:

    A. 1 month:

    B. 3 months:

    C. 6 months:

15. At what point in your life were you the MOST pleased with your health and appearance?

Current Nutrition Information:

1- How would you describe your nutrition overall?

2- Describe a typical daily menu from (include snacks and times):

3- How much protein do you eat, and what types?

4- How many carbs do you eat, and what types?

5- How much fat do you eat, and what types?

6- Do you like to cook, or do you have time to cook?

7- How often do you eat fast food and what types?

8- What would you say is your main dietary weakness?

9- What foods do you crave the most?

10- What foods don't you like AT ALL?

11- What do you drink (how much water, sodas, sweet tea, juices)?

12- Are you able/willing to take food with you to work?

13- Have you ever taken any nutritional supplements? If so, which ones?

15- Do you take any supplements now?

16-What supplements do you feel have worked for you in the past?

Medical Information:

Please check any recurring symptoms that may affect your nutrition program

General
___Fever
___Chills
___Fatigue
___Weight Loss
___Loss of Appetite

Ear, Nose, Throat
___Sinus problems

Endocrine
___Heat intolerance/ Cold intolerance

Cardiac
___Palpitations
___Chest pain
___Shortness of breath w/ exertion

Respiratory / Chest
___Wheezing
___Difficulty/Pain breathing
___Snoring

Gastrointestinal
___Poor Appetite
___Nausea
___Constipation
___Diarrhea
___Heartburn

Hematology
___Leg or Arm Swelling

Vascular
___Pain in legs after exertion

Musculoskeletal
___Muscle weakness
___Muscle stiffness
___Joint pain
___Joint stiffness

Psychiatric
___Depression/Anxiety
___Difficulty Sleeping

Neurologic
___Numbness/Tingling
___Unsteadiness/Difficulty walking
___Dizziness
___Weakness
___Nerve Pain

Measurements	
Shoulders	
Chest	
Chest/Bust	
Abd (Ribs)	
Abd (Umb)	
Arm (L)	
Flexed (L)	
Arm (R)	
Flexed (R)	
Thigh (L)	
Thigh (R)	
Calf (L)	
Calf (R)	

1. **Vitals:**

Wt: _____Lbs. Height: ____Ft.___in.___ BMI: _____

BP: _____ Pulse: _____BF%_____

NATION'S BEST
FAMILY HEALTH CARE

Advance Beneficiary Notice of Non-coverage (ABN)

Date: _____ Patient: _____

Insurance: _____

You are receiving this notice because your insurance may not pay for all the services that you receive during your visit today, even some care that you or our health care provider have good reason to think you need. If your insurance does not pay for the services, you may be responsible for payment.

WHAT YOU NEED TO DO NOW:

• Read this notice, so you can make an informed decision about your care.

• Ask us any questions that you may have after you finish reading.

• Choose an option below about whether to receive the services listed above.

Services and Supplies	Reason Insurance May NotPay	Estimated Cost
Nutrition Counseling	Non covered Service	$75
Mental Health Counseling	Not Deemed Medically Necessary	$50

_____ YES I want to receive these services. If my commercial insurance carrier denies payment, I am completely responsible for payment in full. I understand that I can appeal this decision for nonpayment by my insurance carrier.

_____ NO I have decided not to receive these services.

_____ OTHER Should I decide to request these services in the future, I understand I will be charged and am responsible for payment in full. By signing this notice you agree to take financial responsibility for the cost of the supplies and services listed above should your insurance company deny coverage for the listed items.

This ABN is valid 01/01/18-12/31/18 Patient Initials_____

Signature:_____ Date: _____

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