Adult Nutrition Assessment Form

Name _____ Birth Date_____ Age_____
Address _____
Telephone numbers _____ E-mail _____
Primary Care Physician _____
Health Insurance _____
Referred by _____
Today's Date _____

What concerns do you have about your diet and your health?

How can I help you? What kind of information and support are you looking for?

What are you doing for physical activity?

How much quality sleep time do you have per day?

Do you experience constipation, diarrhea, loose stool, heart burn, gas, or bloating? Difficulty swallowing?

List foods that you are allergic or digestively sensitive to and your reaction:

Height _____ Current weight _____
What is your desirable weight range _____

List all medications, vitamin, mineral, and herbal supplements that you are taking:
_____ _____ _____
_____ _____ _____
_____ _____ _____

Describe your health history and approximate date of diagnosis:
_____ _____
_____ _____
_____ _____
List significant diseases in your family's health history:
_____ _____
_____ _____

How would you describe your appetite?

Are there any foods or textures you dislike?

Do you feel in control of your eating? Please describe:

Do you have a history of disordered eating? Please describe:

Describe any special diets you have followed in the past and how they affected you:

Do you enjoy cooking?

Who does the grocery shopping and where?

How often do you eat out and where?

Consent for Treatment and Authorization Form
for use of Protected Health Information

Patient Name: _____ DOB: _____

Parent/Guardian: _____ (applies only to patients under 18 years of age)

I hereby consent to participating in nutrition counseling and understand that all information I provide is private, confidential, and protected by law as described in the Notice of Privacy Practices.
I hereby authorize any insurance benefits to be paid directly to Melissa Snow, RD, LD Nutrition Therapist and recognize my responsibility to pay all non-covered services.
When necessary to coordinate my nutrition and healthcare, my protected health information may be obtained from and/or provided to my:

- Insurance Company
- Primary Care Doctor: _____
  Address: _____
  Phone: _____ Fax: _____
- Other Doctor (Relationship: _____)
  Name: _____
  Address: _____
  Phone: _____ Fax: _____
- Psychologist or Counselor: _____
  Address: _____
  Phone: _____ Fax: _____

Melissa Snow, RD, LD is hereby released from legal responsibility or liability for the release of information authorized herein. I understand that I have the right to revoke this authorization in writing at any time by sending notification to Melissa Snow, RD, LD at the address below. I understand that I have the right to (1) inspect or obtain a copy of the protected health information to be provided as permitted under federal and state law, and (2) refuse to sign this authorization. My signature indicates my understanding and acceptance of the above policies.

Patient Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

Melissa Snow, RD, LD Nutrition Therapist
100 Shattuck Way, Newington, NH 03801
Phone: 603-431-6677 Fax: 603-766-1966