Melissa Snow, RDN, LD
Adult Nutrition Assessment Form

Name _____ Date of Birth_____ Age_____
Address _____
Telephone number _____ E-mail _____
Primary Care Physician _____
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?

How much quality sleep time do you receive per day?

Do you experience constipation, diarrhea, loose stool, heart burn, gas, or bloating? Difficulty swallowing? Please circle all that apply.

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

Food	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:
_____ _____
_____ _____
_____ _____

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How would you describe your appetite?

Are there any foods or textures you dislike? If yes, please list below.

Do you feel in control of your eating? Please describe why or why not.

Do you have a history of disordered eating? Please describe if so.

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

Do you enjoy cooking? Yes / No
What brings you joy?

What do you do for physical fitness?

How much time per day do you spend on social media?

Who does the grocery shopping and where?

How often do you eat out and where?

Please describe below what you typically have for meals, snacks, and beverages.

Breakfast	Lunch	Dinner

Snacks	
Beverages	

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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 participate 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, RDN, LD Nutrition Therapist and recognize my responsibility to pay all non-covered services.

- In order to coordinate my nutrition and healthcare, my protected health information may be obtained from and/or provided to my (list all applicable information):

Insurance Company: _____

Primary Care Doctor: _____
Address: _____
Phone: _____ Fax: _____

Other Doctor (list type): _____
Name: _____
Address: _____
Phone: _____ Fax: _____

Psychologist or Counselor:_____
Address: _____
Phone: _____ Fax: _____

Melissa Snow, RDN, 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, RDN, 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.

Cancellation/No Show Policy: Helping you meet your goals is important to me, so I've reserved this block of time specifically for you. I also understand that sometimes in life, unexpected things come up. If you find there's no way for you to keep this scheduled appointment, please give at least 24 hours notice to reschedule or cancel by phone or email. If you are unable to give at least 24 hours notice, a $50 late cancellation fee will be billed to you. Thank you for your cooperation.

My signature below indicates my understanding and acceptance of the above policies.

Patient Signature _____ Date _____
Parent/Guardian Signature _____ Date _____