Melissa Snow, RDN, LD
Digestive Health History Form

Name: _____ DOB: _____ Age: _____

Address: _____

Telephone: _____ Email: _____

Health Insurance: _____

Gastroenterologist: _____ Primary Care Provider: _____

Height: _____ Weight: _____ Unintentional weight loss or gain: _____

GI Diagnosis: _____

Other Diagnoses: _____

Family History of GI Diagnosis: _____

Food Allergies: _____

Are you on town or well water? _____ If well water, has it been tested recently? _____

Do you have a history of food borne illness? _____

Do your symptoms correspond to traveling or living in a foreign country? Please explain:

Have you been tested for any of the following? Include test date and results:

Colonoscopy	Test Date:	Results:
Endoscopy	Test Date:	Results:
Celiac Blood Test	Test Date:	Results:
Duodenal Biopsy	Test Date:	Results:
Lactose Intolerance Test	Test Date:	Results:
SIBO Testing (methane and/or hydrogen)	Test Date: Test Source: 1 hour 2 hour 3 hour	Results:
Food allergy testing (IgE/RAST and/or IgG)	Test Date:	Results:
Vitamin D levels	Test Date:	Results:
Thyroid Function	Test Date:	Results:
Other test (please list)	Test Date:	Results:

Melissa Snow, RDN, LD
Digestive Health History Form

Primary Symptoms that you are currently experiencing may include the following.
Please circle the intensity (0 = none, 5 = severe) and frequency of your symptoms:

Gas	0	1	2	3	4	5
	Daily	Almost Daily	2-3x/week		1x/week	Not often
Bloating	0	1	2	3	4	5
	Daily	Almost Daily	2-3x/week		1x/week	Not often
Nausea	0	1	2	3	4	5
	Daily	Almost Daily	2-3x/week		1x/week	Not often
Reflux	0	1	2	3	4	5
	Daily	Almost Daily	2-3x/week		1x/week	Not often
Loose Stool	0	1	2	3	4	5
	Daily	Almost Daily	2-3x/week		1x/week	Not often
Diarrhea	0	1	2	3	4	5
	Daily	Almost Daily	2-3x/week		1x/week	Not often
Urgency	0	1	2	3	4	5
	Daily	Almost Daily	2-3x/week		1x/week	Not often
Constipation	0	1	2	3	4	5
	Daily	Almost Daily	2-3x/week		1x/week	Not often
Abdominal Pain	0	1	2	3	4	5
	Daily	Almost Daily	2-3x/week		1x/week	Not often
Difficulty Swallowing	0	1	2	3	4	5
	Daily	Almost Daily	2-3x/week		1x/week	Not often
Incomplete Bowel Movement	0	1	2	3	4	5
	Daily	Almost Daily	2-3x/week		1x/week	Not often
Fecal Incontinence	0	1	2	3	4	5
	Daily	Almost Daily	2-3x/week		1x/week	Not often

Please describe any diet therapies you have tried AND your results:

Melissa Snow, RDN, LD
Digestive Health History Form

Please list supplements and medications with brand names that you are currently taking:

Melissa Snow, RDN, LD
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 _____