***Christina Scribner MS RD CSSD***

• Registered Dietitian • Board Certified Specialist in Sports Dietetics•

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**PATIENT MEDICAL HISTORY FORM**

The following information is very important to your health. Please take the time to fully and completely fill out each page.

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB:\_\_\_\_\_\_\_\_\_\_\_AGE: \_\_\_\_Gender: \_\_\_\_\_\_

Please check one:

**Initial\_\_\_\_\_\_**□ I **DO** give Christina Scribner permission to contact me by **e-mail** by. EMAIL:\_\_\_ **Initial\_\_\_\_\_\_**□ I **DO NOT** give Christina Scribner permission to contacted me by **e-mail**.

**Initial\_\_\_\_\_\_**□ I **DO** give Christina Scribner permission to leave a confidential message at the following **phone** numbers: Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Initial\_\_\_\_\_\_**□ I **DO NOT** give Christina Scribner permission to leave a confidential **phone** message.

**Initial\_\_\_\_\_\_**□ I **DO** give Christina Scribner permission to leave a phone **text** message at the following **phone** numbers: Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Initial\_\_\_\_\_\_**□ I **DO NOT** give Christina Scribner permission to leave a phone **text** message.

Reason for visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any recent diagnostic tests for this problem? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who is your Primary Care Physician? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

### Referred by:

□ Self □ Health care provider….. Name? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Coach □ Other………\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Why do you want to see the nutritionist?**  (Check all that apply)

|  |  |  |
| --- | --- | --- |
| 1. □ General healthy eating advice | 1. □ Sport nutrition advice | 1. □ High cholesterol |
| 1. □ Want to lose weight | 1. □ Vegetarian eating | 1. □ High blood pressure |
| 1. □ Want to gain muscle/weight | 1. □ Disordered eating/eating concerns | 1. □ Diabetes |
| 1. □ Gastrointestinal problems | 1. □ Food sensitivity/allergy/ intolerance | 1. □ Fatigue |
| 1. □ Other (please explain): \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |

How long have you had this condition/disease?

Symptoms associated with this condition/disease:

How has your life been effected by your medical condition?

What strengths/skills/personality characteristics do you bring to this problem that will help you overcome it?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current and Past Medical Treatment: Date or age at time of treatment

|  |  |
| --- | --- |
| Treatment for: | Date: |
|  |  |
|  |  |
|  |  |

**CURRENT MEDICATIONS:**

Medication Dose Frequency Medication Dose Frequency List all medications you are taking:

|  |  |  |  |
| --- | --- | --- | --- |
| Medication | Time of Day | Amount | Reason for Taking |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**SOCIAL HISTORY:**

**Ethnicity/Race: If bi-racial, or multi-racial please check all that apply:**

□ African-American □ Arab American □ Asian

□ Pacific Islander □ Caucasian, European-American

□ Chicano, Latino, Hispanic □ Native American□ Alaskan Native

□ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

### Religious Affiliation/Spirituality:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

### Is spirituality *or* religion an important part of health care for you? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

### Do you identify as having a disability? □ No □ Yes If Yes, please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you a parent? □ No □ Yes If, Yes, please list the age & gender of your children: \_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_

### STUDENTS ONLY Major: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**College Class**: □Freshman □Sophomore □Junior □Senior □5th Year □Graduate □Transfer Student □Continuing Education Other: \_\_\_\_\_\_\_\_\_\_

**School Status:** □Full-time □Part-time

**Housing:** □Residence: □Residence Hall □Off-Campus □Greek

**Secondary School**: □Freshman □Sophomore □Junior □Senior   
Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   
Name of School:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EMPLOYMENT**

Employment**:** □Full-time □Part-time Type of Work: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Volunteer work: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**LIVING CONDITIONS:**Current Relationship Status:  
□ Single □ Married or Partnered □ Separated □ Divorced □ Widowed □ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Who do you live with? □ Roommate □ Spouse □ Children □ Parents □ Other \_\_\_\_\_\_\_\_  
Are you satisfied with the living arrangement? □ Yes □ No   
Explanation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who shops for food? □ Self □ Roommate □ Spouse □ Parents □ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
 Who cooks? □ Self □ Roommate □ Spouse □ Parents □ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
 What types of transportation do you use? □ Walk □ Bicycle □ Skateboard □ Auto □ Bus □ Other \_\_\_\_\_

**PATIENT AND FAMILY MEDICAL HISTORY**

**PERSONAL Medical History: Place a check mark in front of the conditions you have or have had**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Allergies (food) |  | Anemia |  | Arthritis |
|  | Back Pain |  | Cancer (type \_\_\_\_\_\_\_\_) |  | Constipation |
|  | Diabetes |  | Diarrhea |  | Dental/Chewing |
|  | Dizziness |  | Eating Disorder |  | Fainting |
|  | Food Sensitivities |  | Fibromalagia |  | Gastrointestinal |
|  | Gallbladder Disorder |  | Gout |  | Hair Loss |
|  | High Blood Pressure |  | High Blood Cholesterol |  | High Blood Triglycerides |
|  | Heart Disease |  | Hypoglycemia |  | Irregular Heart Beat |
|  | Kidney Disease |  | Liver Disease |  | Migraines |
|  | Muscle/Joint |  | Osteoporosis/osteopenia |  | Other Allergies |
|  | Overweight/Obesity |  | Polycystic Ovaries |  | Reflux/Heartburn |
|  | Sleep Apnea |  | Thyroid Problems |  | Urinary tract infections |
|  | Ulcer |  | Victim of Abuse |  | Sexually Transmitted |
|  | Depression |  | Anxiety Disorder |  | Substance Abuse |
|  | Other \_\_\_\_\_\_\_\_\_\_\_\_ |  | Other\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Abnormal Labs  or  Family History | | | | Date of Labs: | |
| List Any Foods You are Allergic to: | | | | | |
| List Any Foods You do not Tolerate (but are not allergic to): | | | | | |

Do you commonly experience any of the following symptoms?  (Check all that apply)

Fatigue/Low energy

Cold sensitivity

Loss of appetite

Light-headedness/dizziness

Extreme hunger

Irritability or moodiness

Frequent illness or injury

Poor concentration

Thinking about food, eating, or not eating often

**FOR FEMALES ONLY:**

1) Do you have regular menstrual periods?       Y           N

2) Have you ever lost your period for three months or longer?   Y           N

3) Do you take oral contraceptives?            Y           N

**SLEEP PHYSICAL ACTIVITY**

What time do you generally go to bed? \_\_\_\_\_\_\_\_am/pm

What time do you generally wake‐up? \_\_\_\_\_\_\_\_ am/pm

On average, how many hours do you sleep per night/day?   
 3-5       6-7        7-9       10 or more Is this enough?    Y           N

Please identify your typical level of physical activity:

Level 1: Activities of Daily Living Only

Level 2: Activities Equivalent to Walking 2-3 miles/d plus other Activities of Daily Living

Level 3:  Activities Equivalent to Walking ~5-8miles/d plus other Activities of Daily Living

Level 4:  Activities Equivalent to Walking ~10-20 miles/d plus other Activities of Daily Living

Regular weekday physical activities include:

|  |  |  |  |
| --- | --- | --- | --- |
| Type of activity: | Frequency (days/week): | Duration (length of workout): | Intensity (light. moderate, high): |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

Regular physical activities on weekends includes:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please identify anything that limits or prevents you from being physically active:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever felt that your exercise was compulsive and or excessive? **Y****N**

Are you are a student‐athlete? **Y****N**    
          
 Intercollegiate or Intramural Team; (Please specify which team: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

School Team; (Please specify which team: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

**Quality of Life:**

**Please evaluate the following**

How would you describe your personality Type?  
□ Impatient □ Time-oriented □ Competitive

□ Usually somewhat relaxed □ Sometimes anxious □ Relaxed and easy going

Stress Level……………………….. □ Low □ Moderate □ Severe

Major Sources of Stress \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Do practice stress-reduction techniques? □ No □ Yes If yes, please describe: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  
Quality of Social Life ……………. □ V. Poor □ Poor □ Adequate □ Good □ Excellent

Quality of Mental Health………… □ V. Poor □ Poor □ Adequate □ Good □ Excellent

Quality of Physical Health……… □ V. Poor □ Poor □ Adequate □ Good □ Excellent  
Do you have a support system? □ No □ Yes Who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**BODY WEIGHT**

What is your current body weight? **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

What is your current body height? **\_\_\_\_\_\_\_\_\_\_\_\_**

How long have you been at your current weight? \_\_\_\_\_**\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_

Lowest adult weight:  \_\_\_\_\_ lbs   When?  \_\_\_\_\_/\_\_\_\_\_   (month/year)

Highest adult weight:\_\_**\_\_\_\_\_\_\_\_** lbs   When?  \_\_\_\_\_/\_\_\_\_\_   (month/year)

What do you consider to be your “best” weight? \_\_\_\_\_\_\_\_\_\_\_ Why? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**BODY IMAGE**

Are you satisfied with your body weight and shape? **Y****N**    
If not, what change(s) would you like?

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Frequency of Weighing Self:

multiple times per day  once daily  once weekly  infrequently  varies based on moods

**WEIGHT MANAGEMENT**

Have you ever tried to lose weight? No  Yes

Types of weight management used in the PAST:

Restriction/Diets  Skipping Meals  Vomiting  Chewing and Spitting  Laxatives  Diet Pills  Exercise

Types of weight management used NOW:

Restriction/Diets  Skipping Meals  Vomiting  Chewing and Spitting

Laxatives  Diet Pills  Exercise

Do you believe any of these methods are successful methods of weight management for you?

No Yes

**EATING PATTERN**

Where do you eat most of your meals? (Check all that apply)

Self-Preparation

Residence Hall

Campus Convenience Store

Student Center (please specify:\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_\_\_)

Restaurants (please specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

Other (please specify: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_)

How many times per day (meals + snacks) do you eat?   1-2 3-4 5-6 6-8 9+

How many days per week do you eat “breakfast”?  1-2 3-4 5-6 6-7

What time do you generally eat your largest meal?    
 morning noon mid-afternoon late afternoon evening

What meal is most frequently skipped?   morning noon evening

Do you follow any special diet or food pattern (e.g. low‐fat, vegetarian, religious guidelines)?       
 **Y****N**        
If yes, please describe:\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you usually go to bed feeling hungry? **Y****N**

Do you usually go to bed feeling overly full? **Y****N**

Does your eating or weight feel out of control?     **Y****N**

Do you consciously limit or avoid any of the following foods: (Check all that apply)

|  |  |  |  |
| --- | --- | --- | --- |
|  |  | |  |
| 1. Red meat | 1. Milk | 1. Sweets | 1. Butter/margarine |
| 1. Chicken | 1. Cheese | 1. Grains (i.e. rice, pasta) | 1. Other(s) – please list: |
| 1. Seafood | 1. Oils/dressings | 1. Breads |  |
| 1. Turkey | 1. Vegetables | 1. Fast food |  |

How many servings of fruit do you eat per day?     0 to 1         2 to 3         4 to 5        > 5

(ONE SERVING = 1 tennis ball sized piece of fruit OR 1 cup chopped fruit OR ½ cup (4 oz) 100% fruit juice)

How many servings of vegetables do you eat per day?  0 to 1        2 to 3         4 to 5        > 5

(ONE SERVING = ½ cup cooked vegetables OR 1 cup raw vegetables OR ½ cup (4 oz) vegetable juice)

How many servings of proteins do you eat per day   
(ONE SERVING =  meat, poultry, or fish the size of a deck of cards; 2 Tablespoons nuts or nut butter, 1-2 eggs, ½ cup beans such as pinto, garbanzo, black, refried)  0 to 1        2 to 3         4 to 5        > 5

How many servings of calcium-rich dairy foods do you eat per day   
(ONE SERVING = 1 c (8 oz) milk, soy milk, goat’s milk or 1. c yogurt,1 ½ oz natural cheese, processed cheese, 2 c cottage cheese, 1 c pudding, 1 ½ cu ice cream or frozen yogurt)

 0 to 1        2 to 3         4 to 5

How many days per week do you eat cookies, cakes, pies, candy   
  0 to 1        2 to 3         4 to 5        6-7

How many days per week do you eat fast foods  0 to 1        2 to 3         4 to 5        6-7

How many days per week do you eat fried foods, snack chips   
  0 to 1        2 to 3         4 to 5        6-7

Q: How many days per week do you eat high fat meats and high fat dairy (e.g., hot dogs, sausage, whole milk, whole milk cheese)   
  0 to 1        2 to 3         4 to 5        6-7

Q: Approximately how many cups of fluid (all beverages including milk, juice and broth-type soups) do you consume each day?

 < 2 cups (less than 16 oz)    2 to 4 cups (16-32 oz)     5-6 cups (40-48oz)    7-8 cups (56-64 oz)

Do you drink caffeinated beverages (i.e. coffee, tea, soda)?   **Y** **N**Amount daily?\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

1. **SUBSTANCE USE**
2. Do you drink alcoholic beverages?    **Y****N**    
    How many days per week do you use Beer or Wine?
   * 1. 0 to 1        2 to 3         4 to 5        6-7

How many days per week do you use Hard Liquor?   
  0 to 1        2 to 3         4 to 5        6-7

Do you use Tobacco?  **Y****N**     
 Pipe or Cigar Cigarettes a Day Chewing Tobacco

Recreational Substance use may affect nutrition; Do you use any? **Y****N** 

Marijuana Cocaine Ecstasy Acid Mushrooms

Steroids or Pro-hormones Prescription Drugs used without Prescription \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **SUPPLEMENT USE**

Do you take any vitamin, herbal, or nutritional supplements?   **Y****N** 

Please List type and amount:

**TYPICAL DIETARY INTAKE:**

**Please fill in the following table with an example of what you *typically* eat**

|  |  |  |
| --- | --- | --- |
| **Time** | **Food Eaten** | **Where/With Whom** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

How much reluctance do you feel about coming in for nutrition counseling?

□ No reluctance at all

□ Very little reluctance

□ Some reluctance

□ Quite a bit of reluctance

□ Strong reluctance

Please explain:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What do you hope to achieve as a result of nutrition counseling?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Rate how important this change is to you (0 not at all, 10 extremely):     
 0       1       2       3       4       5       6       7       8       9       10

Rate how confident you are to make this change at this time:       
 0       1       2       3       4       5       6       7       8       9       10

What barriers, if any, stand in the way of you achieving your nutritional goals?

Do you see a psychotherapist? **Y****N** 

Do you have an interest in seeing a psychotherapist? **Y****N** 

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I have seen and have access to a copy of Encompass Nutrition / Christina Scribner’s Privacy Policy Practices   
 **Y**Initial\_\_\_\_\_\_**N** Initial\_\_\_\_\_\_

This information I give to the best of my knowledge:

Client’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Provider Notes:

Reviewed by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(REV. 2014)