ToBetterHealth LLC
Weight Loss to Wellness Nutrition Services

PEDIATRIC / ADOLESCENT PATIENT INFORMATION

Thank you for scheduling your nutrition appointment. Please check your email address provided during scheduling for your appointment confirmation. Add the appointment **DATE, TIME and LOCATION** to your calendar. For **TELEHEALTH** appointments, please add the appointment time to your calendar and look for your emailed video link if not speaking with us via phone, FaceTime or another virtual communication technology that does not require a weblink.

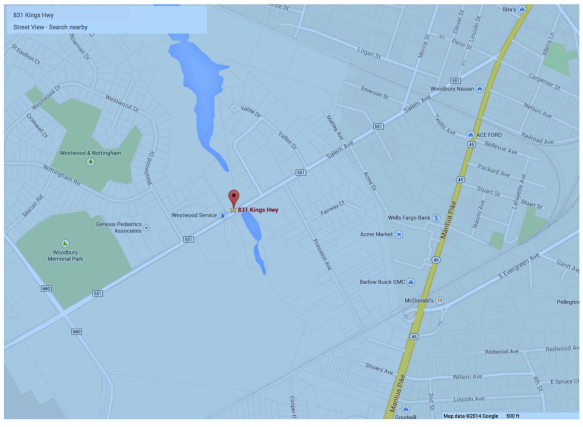
Please be EARLY or ON-TIME to in-person appointments or ready to connect virtually with us for telehealth appointments.

OUR PHONE/FAX NUMBER IS 844-223-6973 (844-2Be-MyRD).
Website: www.tobetterhealthnutrition.com
Email: info@tobetterhealthnutrition.com

Please fill out this patient form and return it to us via fax, email or regular mail.
Our mailing address is:

To Better Health LLC
Sherwood Mews
831 Kings Highway
Suite 200, Second Floor
West Deptford, NJ 08096

Directions: Located on Kings Highway/Salem Avenue across from the Westwood Golf Course. We are in the Sherwood Mews complex (brick and beige/taupe building). We are SOUTH of Acme Drive and Booth Radiology and NEXT TO LukeOil Gas Station that is close to Food Pantry (formerly Wawa). Park in the lot. Come to the building with South Jersey Family Medicine and Edward Jones. Look for the To Better Health, LLC sign on the front of building. Enter door and proceed up steps to second floor.

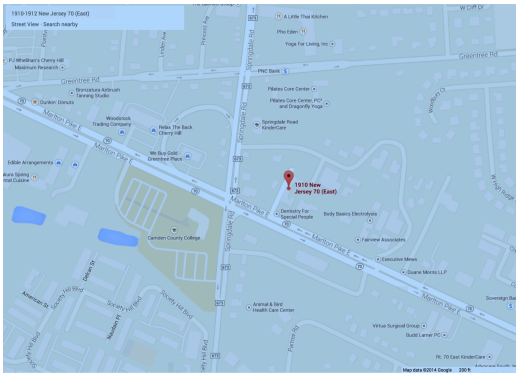


PEDIATRIC / ADOLESCENT PATIENT INFORMATION

CHERRY HILL OFFICE:

To Better Health LLC c/o
The Center for Emotional Health of Greater Philadelphia
Atrium Professional Building
1910 Route 70 East, Suite 5
Counsel Room 6
Cherry Hill NJ 08003

Directions to 1910 Route 70 East: Take I-295 Exit to 70 E. Proceed to the corner of Route 70 and Springdale Avenue. Stay in LEFT lane. Go through traffic light. Make U turn. Medical building complex is on the LEFT close to jewelry store and Building 1908. Enter 1910 Atrium Professional Building parking lot and park. Walk thru courtyard. **Look for Suite 5 - The Center for Emotional Health of Greater Philadelphia. We are located INSIDE the Center for Emotional Health offices.**



BEFORE YOUR APPOINTMENT:

- **Please email** to **kelly@tobetterhealthnutrition.com** and **andi@tobetterhealthnutrition.com** or **fax** to **844-223-6973** (844-2Be-MyRD) **or mail back to us a copy of the FRONT and BACK of your INSURANCE CARD, DRIVER'S LICENSE.** PLEASE NOTIFY US ABOUT AND PROVIDE US WITH DETAILS OF ANY CHANGES IN INSURANCE THAT GO INTO EFFECT BEFORE YOUR CURRENT OR NEXT APPOINTMENT.

- **Please FILL OUT and SIGN the enclosed CLIENT INFORMATION FORM**.

- Please **fax** to **844-223-6973** (844-2Be-MyRD) OR **email** the completed CLIENT INFORMATION FORM to **kelly@tobetterhealthnutrition.com** and **andi@tobetterhealthnutrition.com** ***no later than ONE WEEK BEFORE*** your scheduled appointment. **You may also mail completed form to: To Better Health, LLC, 831 Kings Highway, Suite 200, Second Floor, West Deptford, NJ 08096**. PLEASE keep a COPY of your completed form for your files.

ToBetterHealth LLC
Weight Loss to Wellness Nutrition Services

PEDIATRIC / ADOLESCENT PATIENT INFORMATION

- **Before your appointment, we will need from your family doctor a REFERRAL/SCRIPT if it is required by your insurance company for nutrition counseling. Please obtain a REFERRAL from your primary care physician <u>if required by your insurance company for specialist visits</u>.** Please have your doctor UPDATE YOUR REFERRAL for follow-up visits BEFORE the referral EXPIRATION DATE. PLEASE NOTE THAT ELECTRONIC REFERRALS ARE REQUIRED BY MANY INSURANCE PLANS FOR SPECIALIST'S VISITS. Check your plan to see if you need a REFERRAL. Contact your doctor's office at least 72 hours BEFORE your scheduled appointment to input your referral into the ELECTRONIC system for your To Better Health LLC nutrition visit. Have your doctor's office call us if they need additional information.

- **Please have your doctor FAX or EMAIL a copy of your most recent and, if available, past BLOOD WORK to 844-223-6973 (844-2Be-MyRD)**. This information helps us tailor counseling to best meet your health goals.

- Appointment will be rescheduled if the above items are not presented BEFORE your visit.

- Please provide 72 HOUR CANCELLATION NOTICE if unable to keep your appointment. Missed appointments are subject to a minimum $75 cancellation fee.

DURING YOUR APPOINTMENT:

- **At the time of your appointment, we will collect your COPAY, coinsurance payment or deductible payment specified by your insurance policy.**

IMPORTANT NOTICE ABOUT INSURANCE COVERAGE:

Your insurance company quotes nutrition counseling health insurance benefits to us at the time of scheduling your appointment. However, all health insurance policies state that benefit coverage information provided is not a guarantee of coverage or payment by your health insurance company.

Health insurance copay, co-insurance and/or out-of-pocket fees will depend on what is specified by YOUR health insurance benefit plan.

IT IS YOUR RESPONSIBILITY TO call your insurance company (<u>see the member services phone number on the back of your insurance card</u>) to VERIFY that nutrition counseling IS OR IS NOT covered. Ask your member services insurance representative if your diagnosis is covered for nutrition counseling. Find out about your copay, co-insurance and/or deductible. Fees are collected at the time of the appointment.

THANK YOU

ToBetteHealth LLC
Weight Loss to Wellness Nutrition Services

PEDIATRIC / ADOLESCENT PATIENT INFORMATION

Parent or guardian's information:

Today's Date: _____

Name: First _____ Last: _____ Middle: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home telephone: _____ Work telephone:_____ Cell phone: _____

Email: _____ Fax: _____

Social Security number: _____ Date of Birth: _____

Gender (please circle): Male Female Marital Status: _Married _Divorced _Single Other _____

Ethnic Background: ___Caucasian __African American __Hispanic __Asian __Other _____

Highest Level of Education: ___High School __Some College __College Degree __Graduate Degree

What is your primary language? _____ Your child's? _____

Who referred you? _____

Child's information:

Name of your child (first, middle, last): _____

Child's date of birth: _____ Gender (please circle): Male Female School grade: _____

Emergency contact name: _____ Telephone #: _____

Relationship of emergency contact to your child: _____

List of your physicians / pediatricians (please fill in information below):

Specialty	Name of Physician	Phone	Address	Date of Last Doctor Visit	Next Scheduled Doctor Visit
Family doctor / primary care physician		( ) ____-_____			
Specialist – Type: _____		( ) ____-_____			

ToBetteHealth LLC
Weight Loss to Wellness Nutrition Services

PEDIATRIC / ADOLESCENT PATIENT INFORMATION

WEIGHT HISTORY Today's Date: _____

Current Weight _____ Height _____ Age _____

□ Obesity (95th percentile and above) □ Overweight (85th percentile) □ Underweight (Less than 5th percentile)

Have you experienced any recent weight changes? ____ Weight gain ____weight loss ____ No change

How happy are you with the way you look at your current weight?
□ Very unhappy □ Unhappy □ Neutral □ Satisfied □ Very satisfied

If unhappy about your weight, how old were you when you first became unhappy? _____

How much weight is desired to (check one) □ Lose _____ OR □ Gain _____

Weight history:
6 months ago: Weight _____ Date: _____ 1 year ago: Weight: _____ Date: _____
2 years ago: Weight _____ Date: _____ 5 years ago: Weight _____ Date: _____

Are you teased about your weight by others? __ Yes __ No Are you worried about your weight?__ Yes __ No

Is there anyone else in your household currently trying to lose weight (circle)? __ Yes __ No

Have you ever tried to use laxatives or vomit as a way to lose weight (circle)? __ Yes __ No

At what weight have you felt your best? _____ How long ago (months/years)? _____

What changed or happened in your life to start this weight change? _____

Does your weight affect your daily activities?
□ No Effect □ Some Effect □ Often Interferes □ Extreme Effect

What weight management/fitness/lifestyle products or programs or surgeries have you tried in the past?

□ Exercise on your own Date: _____ □ Gym membership / Date_____
□ Personal Trainer / Date _____

□ Bariatric Surgery Date: _____ □ Bilio-pancreatic diversion with duodenal switch (BPD/DS)
□ Roux-en-Y gastric bypass (RYGB) □ Laparoscopic adjustable gastric band (LAGB)
□ Vertical sleeve gastrectomy (VSG)
□ Appetite control medication / Date _____ □ Appetite stimulant medications / Date _____
□ Fasting / Date: _____ □ Dietitian or nutritionist / Date _____
□ Doctor's weight gain/loss program / Date _____ □ Diet on your own / Date _____
□ Meal replacement bars / Date _____ □ Protein or meal replacement shakes / Date _____

Popular diets used for weight management (check mark all that apply):
□ Atkins Date _____ □ Jenny Craig / Date _____ □ Intermittent Fasting / Date: _____
□ Keto / Date _____ □ Low Carb / Date _____ □ Mediterranean / Date: _____
□ Paleo / Date _____ □ NutriSystem / Date _____ □ Vegetarian / Date: _____
□ Vegan / Date _____ □ Whole 30 / Date _____ □ Weight Watchers / Date _____

ToBetteHealth LLC
Weight Loss to Wellness Nutrition Services

PEDIATRIC / ADOLESCENT PATIENT INFORMATION

SCHOOL / COLLEGE

What grade or college level are you in? Grade Level (Pre-K through 12) _____
College (Freshman through Senior) _____ Graduate School Year (First, Second, Third) _____

WORK HISTORY

□ Unemployed □ Work part-time □ Work full-time □ Retired
How many hours per week do you work? _____ Shift: □ Day □ Evening □ Night

MEDICAL HISTORY

Please mark (X) in □ next to conditions that apply, **including those for which you ARE taking medications**

Cancer

□ Pre-cancer □ Cancer □ Active □ Remission □ Surgery – date(s): _____
Type: _____ Date of diagnosis: _____
How long _____ months/years In remission _____ months/years
Type: _____ Date of diagnosis: _____
How long _____ months/years In remission _____ months/years
Type: _____ Date of diagnosis: _____
How long _____ months/years In remission _____ months/years

Cardiovascular system

□ Aneurysm (abnormal ballooning of weak blood vessel wall) □ Angina (chest pain) □ Angioplasty
□ Atherosclerosis □ Atrial fibrillation (irregular heart electrical impulse)
□ Cerebrovascular disease □ Claudication (cramping from blocked arteries) □ Congestive heart disease
□ Coronary artery disease □ Embolism / blood clot □ Factor V leiden (thrombophilia)
□ Heart attack □ Heart blockage □ Heart disease □ Heart failure □ Heart murmur
□ Hemorrhagic stroke (bursting / weak blood vessels in brain) □ High triglycerides
□ High cholesterol □ Low good (HDL) cholesterol □ High blood pressure □ Low blood pressure
□ Metabolic syndrome (combination of **three or more** of these conditions: high body fat in waistline, high blood pressure, high triglycerides, low good (HDL cholesterol, and/or high fasting blood sugars)
□ Pacemaker or automatic internal cardioverter defibrillator (AICD) □ Peripheral vascular disease
□ Rheumatic Heart □ Stroke / ischemic stroke or TIA (transient ischemic attack) □ Syncope / Fainting
□ Unusual heartbeats / abnormal ECG in last 12 months □ Other - describe: _____

Diabetes Endocrine and Related Conditions

□ Diabetes - Date of diagnosis: _____ □ Type 1 □ Type 2 □ Gestational diabetes during pregnancy
□ Hypoglycemia □ Reactive hypoglycemia □ Insulin resistance □ PCOS (Polycystic ovarian syndrome)
□ Neuropathy/nerve damage □ Poor vision □ Blindness □ Frequent urination □ Excessive thirst
□ Memory loss □ Cellulitis – Where: _____ □ Poor wound healing □ Gangrene □ Amputation

Disordered Eating

□ Anorexia □ Avoidant/restrictive food intake disorder (ARFID) □ Binge eating disorder
□ Bulimia – specify: □ vomiting □ laxative □ excessive exercise □ Picky eating
Diagnosis date: _____ □ Never diagnosed □ No current treatment □ No past treatment
□ Inpatient treatment – Dates: _____ □ Outpatient treatment – Dates: _____
□ Psychological counseling □ Individual cognitive behavioral therapy □ Group therapy

ToBetteHealth LLC
Weight Loss to Wellness Nutrition Services

PEDIATRIC / ADOLESCENT PATIENT INFORMATION

□ Nutrition counseling □ Other behavioral therapy – specify: _____
□ Psychiatric treatment – no medication □ Psychiatric treatment – with medication
Are you current receiving mental health therapy for disordered eating? _____

Gastrointestinal System
□ Abnormal stools – specify: _____ □ Barrett's esophagus □ Cirrhosis (liver)
□ Cancer / Type: □ Colon □ Esophageal □ Liver □ Mouth □ Pancreatic □ Small intestine □ Stomach □ Throat
□ Other gastrointestinal cancer _____
□ Chewing difficulty □ Swallowing difficulty □ Dentures □ Teeth missing
□ Cirrhosis □ Colitis (non-ulcerative) □ Colitis (ulcerative) □ Constipation □ Crohn's disease
□ Diarrhea □ Diverticulitis □ Diverticulosis □ Esophagitis □ Fatty liver – □ Alcoholic □ Non alcoholic
□ Food allergies / intolerances - specify:
□ Alpha Gal □ Beef □ Chicken □ Pork □ Poultry □ Turkey
□ Dairy allergy □ Dairy / lactose intolerance □ Egg yolk □ Egg white
□ Fish - specify: _____ □ Seafood - specify: _____
□ Nuts - specify: _____ □ Peanuts _____ □ Seeds _____
□ Gluten □ Rice □ Wheat □ Corn □ Other grain _____ □ Legumes □ Soy
□ Fruit – specify: _____ □ Vegetable – specify: _____
□ Other food allergies / intolerances - specify: _____
□ Gallbladder disease □ Gallstones □ Gallbladder disease □ Gastric ulcer □ Gastritis □ Gastroparesis
□ GERD (Acid reflux/heartburn/indigestion) □ Hepatitis - Type: □ A □ B □ C □ Hiatal hernia
□ Inflammatory bowel disease □ Irritable bowel syndrome □ Nausea □ Short bowel syndrome
□ Stomach pains/cramps □ Vomiting

Genetic Disorders
□ Down syndrome □ Phenylketonuria □ Other genetic disorder – specify: _____

Kidney Disease
□ Chronic kidney disease □ Glomerulonephritis (inflammation/kidney damage) □ Gout
□ Kidney stones - Hospitalized □ Yes □ No If yes, date(s): _____
□ Other kidney conditions – specify: _____ - Date of diagnosis: _____
□ Kidney failure - Date of diagnosis: _____ □ Hemodialysis - Date started: _____
□ Peritoneal dialysis - Date started: _____ □ Fluid restrictions _____ounces per day
□ Diet restrictions – describe: _____

Liver
□ Alcoholic fatty liver □ Non-alcoholic fatty liver □ Hepatitis - Type: □ A □ B □ C
□ Cirrhosis □ Other liver disease - specify: _____

Mental Health
Stress is high: □ Never □ Rarely □ Sometimes □ Often □ Usually □ Always
□ Anxiety □ Attempted suicide □ Depression □ Obsessive/compulsive disorder
□ Post traumatic stress disorder (PTSD) □ Victim of bullying □ Victim of child abuse
□ Family problems □ Family Housing □ Family legal problems □□ Family money problems
□ Health problems □ Personal or family work problems □ Other describe: _____

ToBetteHealth LLC
Weight Loss to Wellness Nutrition Services

PEDIATRIC / ADOLESCENT PATIENT INFORMATION

Source(s) of emotional support / therapy / stress management:
□ Group counseling □ Individual counseling
□ Licensed clinical psychologist □ Psychiatrist □ Licensed social worker

Please describe any major or traumatic emotional events in your life. When did they happen?
_____
_____

Musculoskeletal System
□ Arthritis - specify: □ Rheumatoid □ Osteoarthritis □ Degenerative disc disease: location: _____
□ Fibromyalgia □ Joint stiffness □ Knee pain □ Lower back pain □ Muscle pain □ Muscle weakness
□ Osteoporosis □ Osteopenia □ Paralysis - □ Partial □ Total □ Prosthesis / artificial limb or joint
□ Other musculoskeletal disease - specify: _____

Neurological / Brain Disorders
□ Epilepsy □ Parkinson's disease □ Multiple sclerosis □ Autism spectrum disorder □ Asperger syndrome
□ Attention Deficit Hyperactivity Disorder (ADHD) □ Attention Deficit Disorder (ADD)
□ Alzheimer's □ Dementia □ Developmental Delay □ Learning Disability □ Memory loss
□ Syncope / Fainting □ Other neurological disorders – describe: _____

Pulmonary System
□ Allergy environmental □ Asthma □ Bronchitis □ COPD □ Cystic fibrosis □ Emphysema
□ Interstitial lung disease (scarring of lung tissue) □ Oxygen therapy □ Sarcoidosis
□ Shortness of breath □ Sleep apnea □ Using C-Pap or Bi-Pap □ Tuberculosis □ Other – specify: _____

Reproductive Health / Men
□ Delayed onset puberty / Age □ Low testosterone □ Infertility
□ Gynecomastia (breast tissue development) □ Hypogonadism (low testosterone)
□ Other conditions – describe: _____

Reproductive Health / Women
□ Amenorrhea - Date of last period: _____ □ Delayed onset puberty / Age onset _____
□ Heavy bleeding with menstruation □ Excessive cramps/pain with menstruation □ Infertility
□ Cervical cancer □ Ovarian cancer □ Ovarian cysts □ Uterine cancer
□ Polycystic ovarian syndrome (PCOS) □ Uterine fibroids □ Other conditions - describe: _____

□ Pregnancy: How many weeks? _____ Expected due date? _____
□ Complications during current pregnancy: □ Gestational diabetes □ Preeclampsia □ High blood pressure
□ Eclampsia □ Edema □ Other – describe: _____
□ Complications during past pregnancy(ies): □ Gestational diabetes □ Preeclampsia □ High blood pressure
□ Breastfed infant(s) – length of time: ____ months □ Did not breastfeed □ Did not want to breastfeed
□ Problem with breastfeeding – specify: _____ □ Post-partum depression

Weeks gestation: _____ Child's birth weight: _____ Current age of child _____
Weeks gestation: _____ Child's birth weight: _____ Current age of child _____
Weeks gestation: _____ Child's birth weight: _____ Current age of child _____

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Weight Loss to Wellness Nutrition Services

PEDIATRIC / ADOLESCENT PATIENT INFORMATION

Sleep Conditions / Sleep Pattern
□ Sleep apnea - Date diagnosed: _____ □ CPAP □ BiPAP □ Not using prescribed CPAP or BiPAP
□ Insomnia □ Chronic fatigue syndrome □ Somnolence/hypersomnolence/sleepiness □ Narcolepsy
How many hours do you sleep at night? _____ Wake up time: _____ Bedtime: _____
How is your sleep quality? □ Poor □ Fair □ Good □ Very good □ Excellent
If sleep quality is fair or poor, what disrupts your sleep? _____

Snore loud (heard through a door or wall): □ Never □ Occasionally □ Frequently □ Don't know
Stop breathing or gasp during sleep: □ Never □ Occasionally □ Frequently □ Don't know
Fall asleep during the day when not active: □ Never □ Occasionally □ Frequently □ Don't know
Fall asleep when driving or stopped at a light: □ Never □ Occasionally □ Frequently □ Don't know

Smoking / Drug Use
Do you or did you smoke? □ Yes □ No
□ Cigarettes / How often □ daily □ weekly □ social occasions. Start date or age _____ Quit date _____
□ Cigars / How often □ daily □ weekly □ social occasions. Start date or age _____ Quit date _____
□ Cannabis/ How often □ daily □ weekly □ social occasions. Start date or age _____ Quit date _____

Chew tobacco? □ Yes □ No / How often □ daily □ weekly. Start date or age _____ Quit date _____
Recreational drugs? □ Yes □ No / How often □ daily □ weekly. Start date or age _____ Quit date _____

Do you take prescription drugs at a frequency greater than that recommended by your physician? _____ If so, why? _____

Thyroid and Gland Conditions
□ Goiter □ Hypothyroidism □ Hyperthyroidism □ Hashimoto's disease □ Parathyroid disorder
□ Thyroid cancer □ Thyroid disease - specify: _____
□ Other gland disorders - describe: _____

Vitamin and/or Mineral Deficiencies / Disorders
□ Calcium □ Potassium □ Anemia – specify: □ Iron □ B12 □ Folic Acid
□ Vitamin D deficiency □ Other vitamin/mineral deficiencies - specify: _____

Surgical History / Hospitalizations:

Condition	Date of Surgery / Hospitalization
_____	_____
_____	_____
_____	_____

Family Medical History

Condition	Family member(s)
_____	_____
_____	_____
_____	_____
_____	_____

ToBetteHealth LLC
Weight Loss to Wellness Nutrition Services

PEDIATRIC / ADOLESCENT PATIENT INFORMATION

MEDICATIONS / SUPPLEMENTS:

Medication allergies: _____

Medications, vitamins, herbal remedies, other supplements:

Medication Name	Start date	Dosage	How Often	Reason for Taking
Vitamins, Herbs, Shakes, etc	**Start date**	**How much**	**How Often**	**Reason for Taking**

PHYSICAL ACTIVITY

Do you exercise? □ Yes □ No If not, why? _____
Do any of your medical conditions restrict you from engaging in physical activity? □ Yes □ No
If so, which conditions _____
□ Medically advised to restrict physical activity □ Personal decision to restrict physical activity
Do you exercise at home? □ Yes □ No Do you currently belong to a gym: □ Yes □ No
If not exercising at home or in a gym, then where? _____
When did you start your physical activity regimen? _____

What type of physical activity do you do? Check all that apply
□ Aerobic classes (step, interval, kickboxing) □ Aerobic exercise machine – type: _____
□ Cycling/Spin – □ indoor □ outdoor □ Dancing – □ ballet □ ballroom □ jazz □ line dancing □ tap □ Zumba
□ Elliptical □ Gardening / Yard work □ Hiking □ Running – circle: indoor, outdoor □ Swimming
□ Strength training / weights □ Snow shoveling manual □ Treadmill □ Video exercises – type: _____
□ Walking □ Water aerobics □ Yoga / Pilates □ Other activity: _____

How many times did you perform the above physical activities in a week: _____
Do you exercise every week? _____ Are you consistent? _____. If not, how often? _____
How long do you exercise each time you workout? _____

Do you play a sport or multiple sports? □ Yes □ No If yes, please fill out below:
□ What type: _____ Length of season: _____ Hours per week _____
□ What type: _____ Length of season: _____ Hours per week _____
□ What type: _____ Length of season: _____ Hours per week _____

Are you getting the results you want/expect: □ Yes □ No

What challenges are you or have you been facing with your exercise program, sport or physical activity regimen? _____

ToBetteHealth LLC
Weight Loss to Wellness Nutrition Services

PEDIATRIC / ADOLESCENT PATIENT INFORMATION

FOOD AND BEVERAGE INTAKE HISTORY

What are your dietary preferences / food restrictions?
□ No restrictions or preferences □ Vegan diet □ Vegetarian diet □ Fluid restrictions □ Low protein diet
□ High protein diet □ Low carbohydrate diet □ High fiber diet □ Low fat diet □ High fat diet
□ No animal products □ Avoid vegetables □ Avoid fruit □ Avoid dairy □ No alcoholic beverages
□ Kosher diet □ Halal diet □ Picky eating / food avoidance □ Other _____
□ Enteral nutrition (tube feeding) – Formula: _____ □ IV nutrition (parenteral nutrition)
□ Nutrition drinks – specify: _____ - Prescribed by doctor? □ Yes □ No

Who does the grocery shopping? _____
Who in the household decides what items go on the shopping list? _____

Who cooks the meals in your household? _____
How often are meals prepared at home? _____ times per day/week/month (circle one)
Are meals prepared from scratch using fresh ingredients? □ Yes □ No
Are meals prepared from boxed, canned, jarred and/or frozen convenience foods? □ Yes □ No
Do you know how to cook? □ Yes □ No Do you like to cook? □ Yes □ No
Do you have time to cook? □ Yes □ No Do medical conditions prevent you from cooking? □ Yes □ No

How many days per week do you eat outside of your home? _____ per day/week/month (circle one)
□ Chain restaurant □ Fast food □ Diner □ Neighborhood restaurant □ Work related event
□ Family gathering / party □ Friend's house party □ Social group meeting □ Other – specify: _____

How often do you bring home takeout food? _____ time(s) per day/week/month (circle one)
□ Asian / Sushi □ Chain (Applebees, Chili's, Outback, etc…) □ Convenience store □ Diner □ Fast food
□ Hoagie □ Pizza □ Cheesesteak □ Grocery store prepared food □ Other: _____

How does your emotional state affect your eating behavior? Fill out the information below.

	Never	Rarely	Sometimes	Often	Usually	Always
I turn to food when I am stressed or upset						
I binge eat						
I feel out of control with my eating						
I think about food a lot						
I eat when I am not physically hungry						
Food helps me deal with my feelings						
I feel in control when I restrict my eating						

Alcohol Beverage Intake

Do you drink alcohol? □ Yes □ No
If yes, how much do you drink (provide the number of drinks per day, week, month, year)?

Beer _____ cans / bottles / pints per □ day □ week □ month □ year
Liquor _____ ounces / bottles per □ day □ week □ month □ year
Wine_____ glasses / bottles per □ day □ week □ month □ year

ToBetteHealth LLC
Weight Loss to Wellness Nutrition Services

PEDIATRIC / ADOLESCENT PATIENT INFORMATION

FOOD AND BEVERAGE INTAKE RECORD

Meal	Time	Food Type / How Prepared	Amount Eaten	Comments
Breakfast				
Beverages				
Snack				
Lunch				
Beverages				
Snack				
Dinner				
Beverages				
Snack				

Notes: _____

_____

ToBetterHealth LLC
Weight Loss to Wellness Nutrition Services

PEDIATRIC / ADOLESCENT PATIENT INFORMATION

GUARANTEE OF PAYMENT

Name of Patient:

_____

Health Plan Name:

_____

Health Plan Individual Member ID #:

_____

Health Plan Group ID #:

_____

Name of Primary Insured (Main person on policy):

_____

Relationship to Patient:

_____

Date of Birth of Primary Insured:

_____

Primary Insured Employer's Name:

_____

Name of Guardian, Power of Attorney and/or Authorized Representative:

_____

Relationship to Patient:

_____

I understand that any nutrition counseling health insurance benefits quoted to me at the time of scheduling are not a guarantee of coverage or payment by my health insurance company.

I understand that my health insurance company will be billed for medical nutrition therapy services rendered to me. I authorize my health insurance company to pay To Better Health, LLC for such services rendered.

I understand that I am responsible for any payments not covered by my health insurance plan and / or if I suffer a lapse in coverage during the period in which nutrition services have been rendered to me for which a claim has been submitted to my insurance company for payment.

I understand that health savings account or bank credit/debit card information is required for copay, coinsurance and deductible payments, or payments not covered by insurance. Visa and Mastercard are accepted. Accounts will be charged to cover all or part of claims not paid by insurance coverage. I agree with the above statements.

_____ _____
Patient or Guardian Signature **Date**

_____ _____
Print Name **Patient Date of Birth**

_____ _____ _____
Credit / Debit Card Number **Expiration Date** **3-digit code on back**

PEDIATRIC / ADOLESCENT PATIENT INFORMATION

RECORDS RELEASE AUTHORIZATION

I have read a copy of the To Better Health HIPAA privacy practice and notice.

I authorize To Better Health LLC to obtain a copy of my medical records and labs from other healthcare providers to assist in providing me with appropriate treatment.

I also authorize the release of medical information from To Better Health, LLC to my health insurance company, other medical providers, and applicable agencies for verification or clarification of diagnosis, treatment, billing and/or payment purposes.

_____ _____

Patient or Guardian Signature **Date**

_____ _____

Print Name **Patient Date of Birth**