YOUTH CLIENT INFORMATION FORM

DATE:_____/_____/_____

NAME_____DIAGNOSIS_____

ADDRESS_____CITY/STATE_____

PHONE_____FAX_____EMAIL_____

DATE OF BIRTH_____AGE_____ SS# _____

HEIGHT_____ESTIMATED WEIGHT_____GOAL (if weight loss needed)_____

PHYSICIAN NAME & ADDRESS_____PHONE #_____

REFERRED BY_____PHONE #_____

MEDICAL HISTORY OR FAMILY HISTORY

(Put an **M** for yourself or **F** for family history)

DIABETES_____ULCER_____HIGH BLOOD PRESSURE_____ANEMIA_____

HEART DISEASE_____EATING DISORDER_____HIGH CHOLESTEROL_____

HIGH TRIGLYCERIDES_____CHEWING OR SWALLOWING PROBLEMS_____

STOMACH OR BOWEL PROBLEMS (explain)_____

CELIAC DISEASE_____NAUSEA OR VOMITING_____FOOD ALLERGIES_____

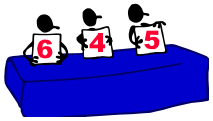
INTOLERANCES_____OTHER_____

SOCIAL HISTORY

GRADE IN SCHOOL____HOBBIES & INTERESTS _____

RECREATION/EXERCISE (what and how often)_____ _____

_____



FOOD PURCHASED BY_____FOOD PREPARED BY_____

MEAL PLANNING BEFORE SHOPPING_____GROCERY LIST DONE BY_____

DIET HISTORY

HAVE YOU EVER BEEN TOLD BY YOUR PHYSICIAN TO MAKE CHANGES IN THE FOODS YOU EAT FOR HEALTH REASONS? YES _____ NO _____

IF YES, WHAT WERE THE CHANGES?_____

HAVE YOU RECEIVED ANY NUTRITION EDUCATIONAL MATERIALS OR NUTRITION COUNSELING IN THE PAST? YES _____ NO_____

COUNSELING WAS PROVIDED BY _____

DID YOU FOLLOW THE RECOMMENDED CHANGES? YES_____ NO_____

MEDICATIONS

Prescription **Over the Counter (i.e. vitamins)**

WEIGHT HISTORY

(ONLY COMPLETE THIS SECTION IF APPROPRIATE)

IS THERE A FAMILY HISTORY OF OBESITY? YES_____ NO_____

IF YES,

EXPLAIN_____

WHAT, IF ANY, WEIGHT LOSS PROGRAMS HAVE YOU TRIED? _____

_____

WHAT HAVE BEEN THE RESULTS?_____

SIGNATURES

I UNDERSTAND THAT I AM RESPONSIBLE FOR THE PAYMENT OF THIS SERVICE IF MY INSURANCE COMPANY DOES NOT PAY.

I UNDERSTAND THAT IF I DO NOT CANCEL MY APPOINTMENT 48hrs. AHEAD I MAY BE RESPONSIBLE FOR THE COST OF THE APPOINTMENT.

I GIVE PERMISSION FOR MARYANN MEADE AND ASSOCIATES TO CALL MY PHONE NUMBER.

I AUTHORIZE THE RELEASE OF ANY MEDICAL OR OTHER INFORMATION TO PROCESS THIS CLAIM.

I AUTHORIZE THE PAYMENT OF MEDICAL BENEFITS TO MARYANN MEADE, M.S., R.D., C.D-M, C.D.E FOR SERVICES PROVIDED.

I UNDERSTAND THAT I AM RESPONSIBLE FOR MY BILLING INCLUDING CO-PAYS OR CO-INSURANCE OR DEDUCTIBLE UNDER MY POLICY.

_____ _____

CLIENT NAME OR AUTHORIZED PERSON

_____/__/_____

SIGNATURE & DATE