



Initial Nutrition Assessment Form

(Please email or fax back the completed form prior to your appointment)

Name: _____

Date: _____

Referred by (friend or physician): _____

1. Please, briefly explain your reason for seeing a Dietitian today:

2. List your top 3 health & wellness concerns in order of importance:

1.

2.

3.

3. What are the main motivators for changing your diet?

a. Improved self-confidence

b. Weight loss

c. Increased energy

d. Improved athletic performance

e. Improved health (ie: blood glucose, cholesterol levels, blood pressure)

f. Prevention of diseases I am at risk for

e. Other: _____

4. On a scale from 1-10 (1 being not at all and 10 being ready today) How ready are you to make lifestyle & diet changes for your health? (Highlight or underline your answer)

< 1 2 3 4 5 6 7 8 9 10 >



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5. Have you tried to make changes to your diet in the past? Yes No

6. What obstacles have you faced or might you face when trying to improve your diet (choose all that apply)?
 - a. Emotional stress
 - b. Work schedule/requirements
 - c. Lack of support from relatives/friends/coworkers
 - d. Lack of time to prepare healthy meals
 - e. Lack of money to buy nutritious foods
 - f. Frequent travel
 - g. Other _____

Diet Log

Below, please provide an example of a typical day of eating – Breakfast – Dinner. Include any snacks, time of meals, and portions

Diagnosed Medical Conditions (please circle if you have any of the following **even if you are taking medication to control the condition**):

Diabetes High blood pressure High cholesterol Obesity Kidney Heart disease



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Cancer Thyroid GI problems Other: _____

What is your primary language?

List of all medications/supplements/vitamins/herbs you are currently taking:

7. Do you smoke? Yes No If yes, how many cigarettes/cigars per day? ____

8. Do you drink alcohol? Yes No

If yes, how often do you consume alcohol?

Daily A few times per week A few times per month

9. How often do you drink coffee?

Never 1 cup/day 2-3 cups/day 4 or more cups/day

10. How often do you consume soda or sweetened beverages like tea or lemonade?

Never daily A few times per week A few times per month

11. Do you often overeat? Yes No

If Yes, how often and why?

12. What types of food do you typically crave?

a. Sweets/desserts



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- b. Chocolate
- c. Bread/pasta
- d. Fried foods/salty foods
- e. Dairy
- f. Meats
- g. Alcoholic beverages

13. Do you experience any of the following if you haven't eaten in a while?

Irritability lightheadedness weakness

14. How often do you eat at home/cook your own meals?

All meals 1-2/day 1/day rarely

15. Who does the cooking/food shopping? _____

16. How often do you have bowel movements?

3+/day 1-2/day every other day once a week or less

17. How often do you urinate in a 24 hour-period? _____

18. The condition of your skin and hair is:

Very dry dry normal oily

19. Please rate your energy level:

Excellent Good Fair Poor

20. How would you rate your quality of sleep?

Excellent Good Fair Poor

How many hours of sleep do you get per night? _____

21. Do you often wake up at night and eat? Yes No



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22. Below, please write how many days a week you exercise, how long each session lasts, and what you do for exercise:

23. Please list any food allergies/sensitivities you have as well as certain foods you avoid for religious or personal reasons:

24. Is there anything else you would like to share with your Dietitian?

Thank You!

**Please give at least 48 hours notice if you cannot keep your appointment to avoid being charged a \$40 fee. For Monday appointments this means you must give notice by Thursday morning at the latest. This fee is reinforced for everyone. Thank you for your consideration **

Weight Questionnaire

(Complete this page only if you are interested in weight loss or weight gain)

1. Describe your present weight:

Very overweight/Obese Slightly overweight Healthy Weight Underweight

2. How do you feel about the way you look at this weight?

Extremely unhappy Unhappy Neutral Happy Very happy

How much do you / did you weigh:

Now: _____



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3 months ago: _____

6 months ago: _____

1 year ago: _____

Height: _____

3. At what weight have you felt your best or do you think you would feel your best? _____

4. How much weight would you like to: Lose or Gain? _____

6. If applicable, please describe your “ideal body” or the physique you would like to obtain?

7. What weight loss/fitness/lifestyle programs have you tried in the past (check all that apply)?

- Diet on your own
- LA Weight Loss
- Weight Watchers
- Exercise at home
- Jenny Craig
- NutriSystem
- Doctor run weight loss
- Gym/Personal Trainer
- Bariatric Surgery
- RD or nutritionist
- Other: _____

f

Client Information Form

Please provide the following information

Date: _____

Full name (first, middle, last): _____

Street Address:

City: _____ State: _____ Zip Code: _____

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

Email: _____ Marital Status: __ Married __ Divorced __ Single __ Other _____

Date of Birth: _____ Gender: __ Male __ Female _____

Insurance Plan: _____ **Insurance Number:** _____

Group number : _____

Name on Insurance card: _____



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Relation to client: _____

*It is recommended you call your insurance plan to find out what your insurance plan covers for nutritional counseling, if Kiwi Nutrition is covered by your plan, how many sessions you have, if you need a doctor referral, and if have a copay, etc.

**In the event that your visit is submitted to insurance and your insurance does not end up paying for your visit, you are responsible for paying the full nutrition-counseling fee.

*** Copay or full appointment fee if paying out of pocket is expected at time of visit. Copy of insurance card will be taken at appointment.

Thank you for reading this carefully.

Name of employer: _____ Occupation: _____

Highest Level of Education: ___ High School ___ Some College ___ College Degree ___ Graduate Degree

Emergency contact name: _____ Telephone number: _____

Relationship of emergency contact to you: _____

Please list all your physicians that you see on a regular basis:

- 1.
- 2.
- 3.

Please write any other questions and concerns that you have:

- 1.
 - 2.
 - 3.
 - 4.
-



5.

6.

Thank You!

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Cancellation Policy

A minimum of 48 hours notice is required for cancelling or rescheduling an appointment. This does not count the weekend. For a Monday appointment please give notice by Thursday morning at the latest. This fee is reinforced for everyone including initial sessions.

A cancellation policy is really important for a nutrition counseling practice because while a medical doctor can see 35 patients in a day, a dietitian like me generally sees a maximum of 6 or 7. I reserve for you, my client, 60-90 minutes of my time for a session. Since the scheduling of an appointment involves the reservation of this time, a cancellation within 48 hours usually leaves professionals like myself unable to re-fill that spot, and therefore I lose 60-90 minutes of my workday.

I care and value all of my clients; I want you to know that my cancellation policy is not a penalty or a punishment. Ninety-nine point nine percent of my clients understand this. Very rarely, I'll have a client who will feel that he or she is being punished when I charge them a



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late cancellation fee. I want to make sure that you don't feel this way, if someday you miss an appointment. I'm never upset with clients when they miss an appointment. I know that's life. In return, my clients understand that scheduling an appointment with me is like buying tickets to an event. If you miss the event, it doesn't matter why you missed it, or even if it was your first time, you can't turn in your tickets for a refund.

A policy like this is simply necessary to protect ones practice and livelihood. Many therapists, nutritionists and the like charge the full session fee, I felt a \$40.00 fee was more reasonable.

With this being said, please note that a no-show or cancellation within 5 hours of an appointment will be charged the full appointment fee.

Please sign below that you have read, understand and agree to the terms above.

X _____



Notice Of Privacy Practices: Kiwi Nutrition Counseling LLC

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal program which requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information. As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records for the following purposes: treatment, payment, and health care operations:

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review.
- Health Care Operations include the business aspects of running the practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services, which may be of interest to you.



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You have the following rights with respect to your protected health information which you can exercise by presenting a written request to Rachel Cuomo at Kiwi Nutrition Counseling

- The right to request restrictions on certain uses and disclosures of protected health information. Including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communication of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of _____.

I acknowledge receiving a copy of the Notice of Privacy Practices of Kiwi Nutrition Counseling LLC on _____ (insert date)

Printed name of patient

Printed name of authorized representative _____

I hereby,

1) Certify that I have received a copy of the HIPPA privacy notice

2) Authorize insurance payments to be sent to the dietitian if applicable



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3) Authorize personal information from nutrition sessions to be disclosed to other treating physicians as needed to continue care

4) I certify that I have received and agreed to the last minute cancellation and missed appointment policies

Patient/Guardian Signature _____ Date _____

Kiwi Nutrition Counseling, LLC

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