NUTRITIONAL ASSESSMENT

Name:		Date:			
Address:					
City:		State:		Zip code:	
Home #:		Cell #:			
Email:					

DOB:		Gender:	☐ Male ☐ Female	
Age:		Height:		Weight:

Status:

☐ Married	☐ Widowed
☐ Separated	☐ Single
☐ Divorce	☐ Partnership

I live with:

☐ Spouse	☐ Children
☐ Partner	☐ Friends
☐ Parents	☐ Alone

Education: ____

Occupation: ______________________________ **Hours / Week:** __________ ☐ **Retired**

Employer: ________________________ **Work Address:** ____________________________

In case of emergency, whom should we contact:

Name	Relationship	Address	Phone

How did you hear about our Wellness and Nutrition Program?

____

____

What is your major complaint? Please list when each symptom began and be as descriptive as possible:

____

____

____

____

____

What are your current medications?

____________________________________ ______________________________________

____________________________________ ______________________________________

____________________________________ ______________________________________

What are your current vitamins / supplements?

____________________________________ ______________________________________

____________________________________ ______________________________________

____________________________________ ______________________________________

Please list your current and past health conditions (e.g. Diabetes Melitus, Fibromyalgia, etc.):

____

____

____

____

____

Please list past or present allergies, including allergies to medications:

____

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TRIAD HEALTH CENTER NOTICE OF PRIVACY PRACTICE

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your Personal Health Information. In addition we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as **dictated by our office policy,** we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. In addition, you will find we have placed several copies in report folders labeled **'HIPAA'** on tables in the reception. Once you have read this notice, please sign the last page, and return to our front desk receptionist.

PERMITTED DISCLOSURES:

1. Treatment purposes - discussion with other health care providers involved in your care.
2. Inadvertent disclosures - open treating area means open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
3. For payment purposes - to obtain payment from your insurance company or any other collateral source.
4. For workers compensation purposes - to process a claim or aid in investigation
5. Emergency - in the event of a medical emergency we may notify a family member.
6. For Public health and safety - in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
7. To Government agencies or Law enforcement – to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government benefits purposes.
9. Deceased persons – discussion with coroners and medical examiners in the event of a patient's death.
10. Telephone calls or emails and appointment reminders - **we may call your home and leave messages** regarding a missed appointment or make you aware of changes in practice hours or upcoming events.
11. Change of ownership - in the event this practice is sold, the new owners would have access to your PHI.

YOUR RIGHTS:

1. To receive an accounting of disclosures
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice
3. To request mailings to an address different than residence
4. To request Restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance
6. To request amendments to information. However, like restrictions, we are not required to agree to them.
7. To obtain **one copy** of your records at no charge, when timely notice is provided (72 hours).

COMPLAINTS:

If you wish to make a formal complaint about how we handle your health information, please call Triad Health Center at (336) 288-4677. If we are unavailable, you may make an appointment with our receptionist to see your Doctor within 72 hours or 3 working days. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Ave. SW
Room 509F HHH Building
Washington DC 20201

I have received a copy of Triad Health Center's Patient Privacy Notice. I understand my rights as well as the practices duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor.

I further understand that this office reserves the right to amend this 'Notice of Privacy Practice" at an time in the future and will make the new provisions effective for all information that it maintains past and present.
I am aware that a more comprehensive version of this "Notice" is available to me and several copies kept in the reception area. At this time, I do not have any questions regarding my rights or any of the information I have received.

____ ______________
Client's Name Client DOB

____ ______________
Client's Signature Date

____ ______________
Staff Witness Date

Nutritional Informed Consent

According to the Federal Food, Drug and Cosmetic Act, as amended, Section 201 (g) (1), the term "DRUG" is defined to mean:
"Articles intended for use in the Diagnosis, Cure, Mitigation, Treatment or Prevention of disease."

A vitamin is not a drug, NEITHER is a Mineral, Trace Element, Amino Acid, Herb, or Homeopathic Remedy.

Although a Vitamin, a Mineral, Trace Element, Amino Acid, or Herb may have an effect on any disease process or symptoms, this does not mean that it can be misrepresented, or be classified as a drug by anyone.

Therefore, please be advised that any suggested nutritional advice or dietary advice is not intended as any primary treatment and or therapy for any disease or particular bodily symptom.

Nutritional counseling, vitamin recommendations, nutritional advice, and the adjunctive schedule of nutrition is provided solely to upgrade the quality of foods in the patient's diet in order to supply good nutrition supporting the physiological and bio-mechanical processes of the human body.

I have read and understand the above information:

____ __________________________
Client Signature **Date**

- Patient Policy Form -

Welcome to Triad Health Center. We are excited to provide you with your health care needs and are honored to work with you to achieve your optimal health goals.

Please review the information below. Sign your initials next to each line item below to indicate you understand our office policies before moving forward, and please sign and date the bottom of this form as acknowledgement of the patient policy contents listed below.

_______ Payment for all services and products is due at the time of the visit. As the patient, you are responsible for the total charges incurred for each visit. We accept Visa, Mastercard, Discover and American Express credit cards, debit cards, checks, and cash for payment. There will be a charge of $25.00 for each returned check.

_______ I give permission for the staff at Triad Health Center and the staff of Triad Health Center to contact me via telephone or email and to leave me messages that may contain appointment or medical information if I am not available.

_______ **Cancellation Policy:** Any appointment time changes or cancellations must be received 24 hours prior to appointment time. Missed consultation without a 24 hour cancellation notification will result in a $75 fee being charged to the client. **Cancellations must be received via phone at 336-288-4677.**

_______ We may recommend natural and alternative supplements, which may be purchased at Triad Health Center. Most insurance companies, Flexible Spending Accounts, and Health Savings Accounts do not cover the supplemental items that we recommend and sell.

I have read and understand the above stated policies and will comply with them in all aspects.

IF TREATMENT IS TERMINATED PRIOR TO PROGRAM COMPLETION, FINANCIAL RESPONSIBILITY TO THE PATIENT IS ASSESSED AT A PER VISIT FEE IF PATIENT IS ON A LONGTERM PROGRAM OPTION. ANY PHONE CALLS OR EMAILS REGARDING ANY ADDITIONAL QUESTIONS OUTSIDE THE SCHEDULED CONSULT WOULD BE OF AN EXTRA CHARGE. ADMINISTRATIVE CHARGES ARE BASED ON 15 MINUTE INCREMENTS AT $25.00 each.

____ __________________________

Client Signature **Today's Date**

3-Day Food Diary

Name: ____________________________________ Date: ________________

Plese list what you have eaten the last three days. If you cannot remember specifics, please list what 3 typical days of eating are.

	Day One	Day Two	Day Three
BREAKFAST			
SNACK			
LUNCH			
SNACK			
DINNER			

Eating Out Preferences

Please list how many days per week you are eating out (1-7) for each meal time, and give examples of your most frequented restaurants.

Breakfast: ___________ Days per week.

Where:____

____

____

Lunch: ___________ Days per week.

Where:____

____

____

Dinner: ___________ Days per week.

Where:____

____

____

What time do you wake up in the morning? ____

What time do you leave your house for work/school/errands?

____

What is your favorite food?

____

What is your favorite restaurant?

____

Do you wake up hungry? ____

TRIAD
Health Center

YOUR TOP 3 HEALTH GOALS:

1) ____

2) ____

3) ____

Basic Nutrition Assessment

Please check the items that apply to you below:

- ☐ Do you eat out more than three times per week?
- ☐ Do you eat boxed foods more than twice per week?
- ☐ Do you drink any type of soda/pop?
- ☐ Do you eat less than five servings of vegetables per day?
- ☐ Do you drink less than four glasses of water per day?
- ☐ Do you feel "addicted" to certain foods?
- ☐ Do you typically opt for lower-fat and lower-calorie foods when given choice?
- ☐ Do you eat white flour, white rice or white bread?
- ☐ Do you use artificial sweeteners, such as aspartame, Splenda, NutraSweet, or consume foods that contain them?
- ☐ Do you eat fried foods more than once per week?
- ☐ Do you eat processed "deli" meat, bacon, sausage or hotdogs?
- ☐ Do you think that you get all your needed nutrients from food and therefore pass on supplements, including multivitamins and fish oil?
- ☐ Do you use canola oil or vegetable oils in cooking or salad dressings?
- ☐ Do you use margarine?
- ☐ Are most of the fruits and vegetables you eat conventionally grown (non-organic)?
- ☐ Do you consume milk and dairy products that are purchased from the grocery store?
- ☐ Are the majority of your animal products purchased from the meat counter or freezer at the grocery store (as opposed to a health food store or local farmer)?
- ☐ Do you consider price and convenience of food to be more important than nutritional quality?
- ☐ Do you eat sweets or candy more than once per week?
- ☐ Do you drink more than 3 alcoholic beverages per week?
- ☐ Do you eat while rushed or under stress?
- ☐ Do you, your doctor, or family think that you need to lose some body fat?
- ☐ Do you have irregular blood sugar, diabetes or pre-diabetes?
- ☐ Do you have blood pressure over 120/80?
- ☐ Do you suffer from sinus conditions, asthma, or allergies (including rashes, eczema, hives)?
- ☐ Do you have gastrointestinal concerns?
- ☐ Do you frequently experience fatigue or insomnia?
- ☐ Do you have emotional/mental challenges or trouble concentrating?
- ☐ Do you suffer from joint pain or muscle aches?
- ☐ Do you have hormonal imbalances?

TOTAL # OF CHECK MARKS = ______

NeuroToxic Assessment

Rate each of the following symptoms to the best of your ability based upon your typical health profile over the last year. If you cannot answer a question, simply leave it blank.

POINT SCALE		
0 = Never had the symptom	2 = Occasionally have it, severe effect	4 = Frequently have it, severe effect
1 = Occasionally	3 = Frequently have it, mild effect	

COLUMN #1

	Anxiety
	Mood Swings
	Excessive shyness, timidity, social phobia (not typical to your personality)
	Irritability (not typical to your personality)
	Low body temperature (below 97.5°)
	Insomnia (can't get to sleep or return to sleep)
	Dizziness
	Psychological symptoms, even thoughts of suicide
	Sensitivity to sound
	Indecisiveness
	Feeling of being overwhelmed or fearful
	Metallic taste in your mouth
	Bad breath
	Bleeding gums
	Sensitive teeth
	Canker sores or other sores in the mouth
	Floaters, shadows or swimmers when you read or look into the sky
	Swelling eyelids
	Peeling on top layer of skin (hands, feet)
	Dry skin
	Heart pain (angina)
	Depression
	Gout (arthritic pain, especially in big toes)
	Pain in shoulders or upper back
	Twitching eyelids
	Anemia (low iron/hemoglobin on blood test)
	Wrist/ankle drop or weak extensor muscles
	Hair falls out (not normal male pattern baldness)

COLUMN #2

	Sensitivity to light
	Fatigue after exercising (feeling worse)
	Shortness of breath, with very little effort
	Excessive thirst and/or frequent urination
	Red eyes or tearing
	Blurred vision at times
	Morning stiffness
	Chronic fatigue or weakness
	Non-restful sleep
	Receive static shock often (doorknobs, car, light switch, people)
	Trouble processing new information
	Word reversal or trouble finding words
	Sensitivity to touch
	Short-term memory loss
	Chronic sinus congestion
	Dry non-productive cough
	Muscle twitching
	Joint pain-not necessarily true arthritis-can more from joint to joint
	Difficulty losing weight regardless of diet or exercise
	Persistent fungal or viral infection, including athletes foot, warts, jock itch
	Frequent illness, prolonged illness
	Numbness or weakness in arms and legs
	Headaches
	Trouble adding or dividing in your head
	Fluctuating constipation and diarrhea
	Stomach pain for no apparent reason
	Appetite swings
	Frequent muscle aches, cramps, unusual sharp sudden pains
	Rashes or rosacea
	Cold extremities (hands and feet)
	TOTAL OF COLUMNS 1 + 2