



**Lifestyle Management Solutions**

### **Welcome!**

I am happy to have you as a new client and look forward to working with you. Should you have any questions, feel free to call (626) 963-5350 or email [LMS@GinaCrome.com](mailto:LMS@GinaCrome.com).

### **Your First Appointment**

Your first appointment will be about 90 minutes in length. Follow-ups are usually scheduled for 1 hour. I will provide you with a receipt appropriate to submit to your insurance provider if you wish to do so.

### **Cancellation & Payment Policies**

In order to maintain the integrity of our practice, we must request that all cancellations be made with a minimum of 24-hour notice. Failure to provide 24-hour notice or a failure to show will result in your account being charged for the visitation at our standard fee.

### **Client Information Forms**

In order to best serve you at your initial nutrition appointment, please print and complete your new client packet that follows prior to your first visit.



Lifestyle Management Solutions

## Client Information

Name \_\_\_\_\_

First

Middle

Last

Address \_\_\_\_\_

Street

City

State

Zip

Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ E-Mail: \_\_\_\_\_

Age \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: M/F Marital Status: S/M/D/W

E-mail: \_\_\_\_\_ Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Occupation or Profession: \_\_\_\_\_ Employer \_\_\_\_\_

Emergency contact: \_\_\_\_\_ Relation: \_\_\_\_\_

Phone:(\_\_\_\_) \_\_\_\_\_ Address: \_\_\_\_\_

Insurance Provider \_\_\_\_\_ Phone:(\_\_\_\_) \_\_\_\_\_

ID # \_\_\_\_\_ Group # \_\_\_\_\_

How did you hear about Lifestyle Management Solutions?

- Google Search       Yelp       CitySearch  
 Physician Referral       Friend       Other \_\_\_\_\_

What would you like this consultation to address? (please check all that apply)

- Diet Assessment for General Wellness/Disease Prevention  
 Weight Management: Please circle one:    Weight Loss      Weight Gain      Weight Maintenance  
 Disordered Eating-please specify: \_\_\_\_\_  
 Blood Glucose Control: Please circle one:    Pre-Diabetes    Type 1    Type 2    Gestational Diabetes)  
 High Blood Pressure  
 Elevated Cholesterol and/or Triglyceride Levels  
 Women's Health-please specify: \_\_\_\_\_  
 Sports Nutrition-please specify sport/activity: \_\_\_\_\_  
 Digestive Issues-please specify: \_\_\_\_\_  
 Diet for Weight Loss Surgery-please specify type of surgery: \_\_\_\_\_

**PERSONAL HEALTH HISTORY** (Please check all that apply)

- |  |  |  |   |
|--|--|--|---|
| <input type="checkbox"/> Asthma                  | <input type="checkbox"/> Food allergies      | <input type="checkbox"/> Irritable Bowel           | <input type="checkbox"/> Other (please specify) |
| <input type="checkbox"/> Cancer                  | <input type="checkbox"/> Food intolerance    | <input type="checkbox"/> Low iron/anemia           | _____   |
| <input type="checkbox"/> Celiac Disease          | <input type="checkbox"/> Frequent colds/flu  | <input type="checkbox"/> Menopause                 | _____   |
| <input type="checkbox"/> Chronic constipation    | <input type="checkbox"/> Frequent headaches  | <input type="checkbox"/> Osteoporosis              |   |
| <input type="checkbox"/> Crohn's Disease         | <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Osteopenia                |   |
| <input type="checkbox"/> Currently pregnant      | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Overweight/Obesity        |   |
| <input type="checkbox"/> Currently breastfeeding | <input type="checkbox"/> High Triglyceride   | <input type="checkbox"/> PCOS                      |   |
| <input type="checkbox"/> Depression/anxiety      | <input type="checkbox"/> High Cholesterol    | <input type="checkbox"/> Surgery (describe: _____) |   |
| <input type="checkbox"/> Diabetes (type: _____)  | <input type="checkbox"/> Hyperthyroidism     | <input type="checkbox"/> Ulcerative Colitis        |   |
| <input type="checkbox"/> Eating Disorder         | <input type="checkbox"/> Hypothyroidism      | <input type="checkbox"/> Vegetarian                |   |

Height \_\_\_\_\_ Current Weight \_\_\_\_\_ Weight Goal \_\_\_\_\_ Weight Range (past 3 years) \_\_\_\_\_-\_\_\_\_\_

Do You Have Trouble Sleeping? Yes No How many hours do you sleep each night? \_\_\_\_\_  
On a scale of 1 to 5, how would you rate your current stress level (1 = Lowest, 5 = Highest)? \_\_\_\_\_

Are you physically active now? Yes No

If Yes, please list activities & frequency:

\_\_\_\_\_

\_\_\_\_\_

How would you rate your present energy level? Poor Normal High

Primary Care Physician & Name of Clinic: \_\_\_\_\_

Medical Conditions: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### Current Medications

Medication/Dosage	Reason for Use	Medications/Dosage	Reason for Use
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\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Previous surgeries (dates/procedure): \_\_\_\_\_

\_\_\_\_\_

Serious injuries or illnesses: \_\_\_\_\_

\_\_\_\_\_

Do you have any allergies that you know of? Yes No If Yes (please specify): \_\_\_\_\_

### Which, if any, of your blood relatives have had any of the following?

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Arthritis          | <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Osteoporosis/Osteopenia |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Stroke                  |
| <input type="checkbox"/> Cancer             | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Tuberculosis            |

### NUTRITIONAL INFORMATION

Do you eat breakfast? Yes No Sometimes

Do you skip meals? Yes No Sometimes

Do you eat when you are not hungry? Yes No Sometimes

Would you say that you are an "emotional eater?" Yes No

Have you had any changes in your appetite lately? Yes No

How many times per week do you eat at restaurants? \_\_\_\_\_ What kind of restaurants? \_\_\_\_\_

Do you smoke or chew tobacco? Yes No If so, how often and for how many years? \_\_\_\_\_

Do you feel that you overeat? Yes No Do you feel that you under-eat? Yes No

Have you lost or gained more than 10 pounds in the past 6 months? Yes No Don't Know

Describe your usual eating environment (in the car, at a table, at desk, etc) \_\_\_\_\_

Are you following a special diet at this time? Yes No If so please describe \_\_\_\_\_

Do you have set meal times? Yes No If so, please specify \_\_\_\_\_

Do you have any food restrictions, dislikes or foods you choose not to eat for any reason?

\_\_\_\_\_

## **3-Day Food Diary**

### **Instructions**

Complete the following food record prior to your first appointment. This 3-day diary is designed for recording three *consecutive* days, including one weekend day if possible. Please record ALL food and drinks at each time of the day you eat or drink. Waiting till the end of the day to fill in your diary will result in lost information. Make sure you fill in as much detail as possible. Include any vitamins, minerals, sports or herbal supplements you are taking. Being as specific as you can about the food type and amounts will help us provide you with a more accurate assessment. Should you have any questions, please feel free to contact our office (626) 963-5350.



**FOOD DIARY: DAY 1**

**DATE:** \_\_\_\_\_

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<b>BREAKFAST</b> Time Eaten: _____	
<b>SNACK(S)</b> Time Eaten: _____	
<b>LUNCH</b> Time Eaten: _____	
<b>SNACK(S)</b> Time Eaten: _____	
<b>DINNER</b> Time Eaten: _____	
<b>SNACK(S)</b> Time Eaten: _____	
<b>Physical Activity (type/amount)</b>	



**FOOD DIARY: DAY 2**

**DATE:** \_\_\_\_\_

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<b>BREAKFAST</b> Time Eaten: _____	
<b>SNACK(S)</b> Time Eaten: _____	
<b>LUNCH</b> Time Eaten: _____	
<b>SNACK(S)</b> Time Eaten: _____	
<b>DINNER</b> Time Eaten: _____	
<b>SNACK(S)</b> Time Eaten: _____	
<b>Physical Activity (type/amount)</b>	



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## FOOD DIARY: DAY 3

DATE: \_\_\_\_\_

<b>BREAKFAST</b> Time Eaten: _____	
<b>SNACK(S)</b> Time Eaten: _____	
<b>LUNCH</b> Time Eaten: _____	
<b>SNACK(S)</b> Time Eaten: _____	
<b>DINNER</b> Time Eaten: _____	
<b>SNACK(S)</b> Time Eaten: _____	
<b>Physical Activity (type/amount)</b>	



## Compliance Assurance Notification For Our Clients

The misuse of Personal Health Information (PHI) has been identified as a national problem causing clients inconvenience, aggravation, and money. We want you to know that all of our providers continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule." We strive to achieve the very highest standards of ethics and integrity in performing services for our clients.

It is our policy to properly determine appropriate use of PHI in accordance with the governmental rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

Our policy is to listen to our employees and our clients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly. Thank you for being one of our highly valued clients.

### Client Acknowledgement Confirming Receipt of HIPAA Privacy Notice

I have received Lifestyle Management Solutions HIPAA Privacy Notice.

\_\_\_\_\_  
Client Name (please print)

**X**\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date

## Consent for Treatment & Authorization For Use of Protected Health Information

Client Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
Parent/Guardian (for clients under 18 years of age) \_\_\_\_\_

I hereby consent to participating in nutrition counseling with Lifestyle Management Solutions and understand that all information I provide is private, confidential, and protected by law as described in the Lifestyle Management Solutions privacy practices. When necessary to coordinate my nutrition and healthcare, and as described in the Lifestyle Management Solutions privacy practices, my protected health information may be obtained from and/or provided to my:

Insurance Company: \_\_\_\_\_

Primary Care Doctor: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Other Doctor: \_\_\_\_\_

Specialty: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Other Health Care Professional: \_\_\_\_\_

Type of Professional: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

*Lifestyle Management Solutions is hereby released from legal responsibility or liability for the release of information authorized herein. I understand that I have the right to revoke this authorization in writing at any time by sending notification to Lifestyle Management Solutions. I understand that I have the right to (1) inspect or obtain a copy of the protected health information to be provided as permitted under federal and state law, and (2) refuse to sign this authorization. My signature below indicates my understanding and acceptance of the above policies.*

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(if client is under 18 years old)