# Corydon Physiotherapy Clinic
Dec. 2014

## *Dietitian services*

### Client Nutrition and Health Form

*Please complete this questionnaire. All information will be kept strictly confidential.*

**Personal Information**
Name: ____________________________________________ Date: ______________________
Address: __________________________________________ Postal code: _________________
Telephone: (H) ________________ (W) ________________ Occupation: _________________
Email Address (very important): ___________________________________________________
(we will not distribute; only used for clinic notices, your exercises and appointment reminders)
Date of Birth: ____________________ Age: _______
Private Insurance Coverage: _____________________
Physician's Name / Address / Tel. No. ____________________________________________
May he / she be notified for your visit(s): Yes No

Please check the box that best tells us how you decided to come here:
Friends or Family ( ) Doctor ( ) Other Healthcare Professional ( ) Yellow Pages Online ( )
Yellow Pages book ( ) Corydon Physiotherapy Website ( ) Kathleen McClinton's Website ( ) Online search ( ) Social Media ( ) Brochures ( ) Other ( ) ______________ (Please Specify)

Preferred method for appointment reminders: Email( ) **or** Phone( ) if so,Home or Work or Cell?

**Medical Background**
Are there any medical conditions, past or present, that the dietitian should be aware of? ______
_____________________________________________________________________________
Family History: _______________________________________________________________
_____________________________________________________________________________
Please list any medications you are presently taking: ___________________________________
_____________________________________________________________________________
_____________________________________________________________________________
Are you taking any vitamin / mineral / herbal supplements? ____________________________
_____________________________________________________________________________
Do you have any food sensitivities or food allergies? __________________________________

**Nutrition & History**
What is the reason for your visit? ___________________________________________________
Do you have any goals in mind for today's visit? _______________________________________
Have you ever visited a registered dietitian or nutritionist? ______________________________
Have you ever been on a nutrition plan/diet before?_____________________________________
If so, what type of diet and for how long? ______________________________________
Do you skip meals? If so, how often? _________________________________________________

Do you drink coffee / tea? Yes No If yes, how many cups/day? ______________________
Do you drink milk? Yes No If yes, how many cups/day? ______________________
Do you drink water? Yes No If yes, how many cups/day? ______________________
How much alcohol do you drink per week?___________________________________________

OVER

Do you avoid any foods for religious / ethical / cultural reasons? ___________________________
Do you smoke?  Yes   No         If yes, how much? _______________________________________
How often do you exercise? ____ What physical activity do you do? ________________________
How much time do you spend watching tv/computer per week?__________

- ✓ **Cancellation Policy: Please note we run a busy clinic accommodating many patients. Not attending also generally means that it will take longer for you to recover. But if for some reason you need to move or cancel future appointments we require <u>24 hours</u> notice otherwise a cancellation fee of $50 may be charged.  We send out email or phone reminders the day prior to your appointment to assist you in that regard.**
- ✓ **It is our policy to receive full payment at each appointment.**
- ✓ **Corydon Physiotherapy <u>does not direct bill</u> insurance companies for Massage or Dietitian services. Due to excessive insurance company errors and delays, we no longer provide this service.**
- ✓ **You are required to pay your account in full at each visit. You then would submit your receipt(s) to your insurer for reimbursement. This is a more streamlined and efficient process versus us billing on your behalf.**

Date: __________________________ Client's Signature: ____________________________________

**Waiver / Acknowledgement**

I, _____________________________ herby grant permission for Corydon Physiotherapy & Massage Clinic to correspond with my physician(s) ____________________________________ to obtain information relevant to my nutrition treatment and counselling. I acknowledge that any information so obtained will be held in strict confidence. I further acknowledge the information provided to me by Kathleen McClinton, Registered Dietitian, is designed to meet my personal dietary needs. It is NOT suitable for other individuals and will not be transferred, copied or sold to another person.

In order to benefit from the treatment prescribed by Kathleen McClinton, RD, I realize that it is important for me to inform either my physician or Kathleen of any changes I make in the application of my diet. It is my responsibility to report any side effects or problems immediately and to make the necessary adjustments to my treatment plan with my physician and / or Kathleen. I will not hold my physician or Kathleen McClinton, RD, responsible for any complications which result from my failure to comply with either of the above.

Date: __________________________

Client's Signature: ______________________________________