

BODY DYNAMICS, INC.

- ♦ Manual, Orthopaedic, and Performing Arts Physical Therapy ♦
- ♦ Polestar® Certified Pilates-based Rehabilitation and Conditioning ♦

Nutrition Services General Information

Date: _____ How did you hear of us? _____

Name: Last: _____ First: _____ M.I.: _____

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: ____/____/____ SSN: _____

Phone: Home: _____ Work: _____

Other: _____ E-Mail: _____ @ _____

Emergency Contact Name: _____ Phone: _____

If you would like us to keep your credit card on file to process after services are rendered please fill out info below.

Credit Card- VISA MASTERCARD AMERICAN EXPRESS DISCOVER- Please circle one.

Credit Card Number	Expiration	Zip Code
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Financial Policy

1. All payments must be made at the time of service. BDI accepts cash, checks, and the following credit cards: VISA, Mastercard, Discover, and American Express.
2. **Cancellation policy:** Because of limited times available and high demand, it is necessary to enforce a strict cancellation policy.
 - a. If a client cancels at least 24 hours prior to the appointment, there is no charge.
 - b. If a client cancels less than 24 hours prior to the appointment or does not show, the client will be charged a fee that is equivalent to the cost of one full session.
3. **Late Policy:** BDI strives to give you our fullest attention during your allotted time. Your respect of other client's time is appreciated and sessions will end promptly as scheduled. Late arrivals are responsible for the full fee of the session.

Please initial that you have read and understand our cancellation policy _____

Fee Schedule

Initial Evaluation	\$125.00
Follow-up Session	\$75.00

Package Rates:

10 one hour follow-up sessions (must be used within 6 months of purchase)	\$720.00
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Signature

Date

NUTRITION ASSESSMENT

Reason for today's visit: _____

1. Have you ever worked with a dietitian/nutritionist? Yes _____ No _____ Reason _____

2. General Health (check one): ___ Excellent ___ Good ___ Fair ___ Poor

3. Have you had any medical problems or hospitalization in the past year? Yes _____ No _____

If 'yes', please specify _____

4. Surgical History: Procedure: _____ Date: _____
 Procedure: _____ Date: _____
 Procedure: _____ Date: _____
 Procedure: _____ Date: _____

5. List any prescription medications you are currently taking:

6. List any Over the Counter medications you are currently taking:

7. List any herbal/vitamin/mineral supplements you are taking:

8. List any food allergies/intolerances: _____

9. Are you currently engaged in a regular exercise program? Yes _____ No _____ Please describe: _____

10. Do you have any injuries that keep you from exercising, or past injuries that kept you from exercising?

11. Any symptoms of: Nausea _____ Vomiting _____ Diarrhea _____ Constipation _____

12. What was your highest adult weight? _____ Lowest adult weight _____

13. Tobacco: Yes _____ No _____ ppd _____ years _____

14. Alcohol: Yes _____ No _____ amount/day/week/mo _____

15. Caffeine: Yes _____ No _____ # drinks/day _____

16. Do you currently have an eating disorder, or a past history of an eating disorder?

17. Present/Past Medical History:

Asthma	Y	N	Heart Attack	Y	N
Arthritis	Y	N	Heart Disease	Y	N
Cancer	Y	N	Hernia	Y	N
Circulatory Disease	Y	N	High Blood Pressure	Y	N
Depression	Y	N	Kidney Disease	Y	N
Diabetes	Y	N	Multiple Sclerosis	Y	N
Dizziness	Y	N	Osteoporosis	Y	N
Eating Disorder	Y	N	Pregnancy	Y	N
Emphysema	Y	N	Stroke	Y	N
Epilepsy	Y	N	Thyroid Problems	Y	N
Fainting	Y	N	Weakness	Y	N
Fatigue	Y	N	Dyspnea	Y	N
Headaches	Y	N	Dysuria	Y	N
Hepatitis	Y	N			
High Cholesterol	Y	N			
Fever/Chills/Sweats	Y	N			
Unexplained Weight Change	Y	N			
Nausea/Vomiting	Y	N			
Bowel Dysfunction	Y	N			
Urinary frequency Change	Y	N			

Comments: _____

Has anyone in your family been treated for any of the conditions listed above? Please list: _____

18. Is there any other medical information concerning your health we should be aware of: _____

19. Has there been a change in your diet due to health in the past 12 months: Yes ____ No ____

20. Diet change reason: overweight/obesity ____ high blood pressure ____ high cholesterol ____
heart disease ____ diabetes ____ allergies ____ ulcer ____ cancer ____ pregnancy ____
health in general ____ other ____ stress ____ depression ____ life change ____

21. List your goals of nutrition counseling _____

FOOD FREQUENCY QUESTIONNAIRE

How often do you eat the following foods per week?

Food	Times per week	Food	Times per week	Food	Times per week
Eggs		Bread		Cake/Cookies/Brownies	
Cheese		Nuts		Ice Cream	
Milk		Rice/Pasta		Frozen Yogurt	
Yogurt		Beans		Water	
Cottage Cheese		Bacon/Sausage		Coffee/Tea	
Pizza		Potatoes		Soda	
Red Meat		Frozen Dinners		Alcohol	
Chicken/Turkey		Fast Food/Carryout		Fruit Juice	
Pork/Ham		Fried Food		Fruits	
Fish		At Restaurant		Vegetables	
Soy Products		Dietary Supplements		Salty Snacks-chips, pretzels, etc	
Margarine/Butter		Oil		Cereal	
Luncheon Meats/Hotdogs		Mayonnaise		Ethnic Food (Chinese, Mexican, Thai, etc)	
Liver/organ meats		Shrimp/clams, etc.		Other	

1) How often do you eat out at restaurants? _____

2) How often do you eat at your desk? _____

3) How often do you eat in your car? _____

4) Where do you eat dinner and other meals while at home? _____
