be nourished

Initial Intake & Assessment

Name _____ Date _____

Address _____

City_____ State _____ Zip _____

Home Phone _____ Work Phone _____

Email address _____ Date of Birth _____

Occupation _____

Preferred Gender Pronoun(s) _____

How did you hear about our services?_____

Referred by _____ Reason for Referral _____

Have you ever worked with a dietitian? Yes ___ No ___ If yes, who/when/why?

Have you ever worked with a therapist? Yes ___ No ___ If yes, who/when/why?

Have you ever worked with a psychiatrist? Yes ___ No ___ If yes, who/when/why?

Are you currently under the care of a medical professional? Yes ___ No ___

Clinic/doctor's name _____

YOUR EMERGENCY CONTACT

Name _____ Relationship _____

Phone number _____ Address _____

MEDICATIONS AND SUPPLEMENTS

List medications you are currently taking:

_____

_____

List vitamin/mineral supplements you are taking:

_____

_____

List herbal remedies you are taking: _____

EATING PATTERNS

The following sections ask questions specific to your relationship with food, eating and your body. Please complete to the best of your ability. You are always welcome to leave an answer blank if it doesn't feel comfortable or safe to answer it now.

Describe what hunger feels like to you: _____

Describe what fullness feels like to you: _____

How do you decide what to eat? _____

How do you know when to stop eating? _____

Do you usually eat when you get hungry? Yes __ No __

Do you often eat when you are not hungry? Yes __ No __

Can you tell the difference between physical hunger and "emotional hunger"? Yes __ No __

What are your favorite foods? _____

_____

Have you ever been diagnosed with an eating disorder? Yes __ No __ If yes, please describe:

_____

Circle any of the following that describes your eating patterns:

a) Eat 3 meals each day

b) Eat a 'normal' amount of food

c) Eat 3 meals with snacks

d) Restrict intake of food

e) Binge without purging

f) Binge followed by vomiting

g) Binge followed by restricting food intake

h) Binge followed by laxatives

i) Binge followed by diuretics

j) Binge followed by exercise

k) Vomit without binging

l) Restrict food intake without binging

m) Use laxatives without binging

n) Use diuretics without binging

o) Exercise excessively without binging

p) Eat in secret

q) Eat in the middle of the night

r) Experience guilt after eating

MOVEMENT

Do you currently get regular physical activity? Yes ___ No ___ Describe:

Do you enjoy it?

Describe past history with exercise/movement:

Do you consider yourself a compulsive exerciser? (Is it hard not to exercise, even if you are tired, sick or not in the mood?) Yes ___ No ___

WEIGHT HISTORY

My treatment model is weight-inclusive, and your relationship with food and/or your body will be the focus of our work. *Understanding your unique body story includes getting a sense of your weight history. Please answer as best you can. If you find any question triggering, you may leave it blank.*

Do you know your current weight? If so, do you want to share it here? _____

Has your weight changed significantly in the past 2-6 months? Yes ___ No ___ If yes, please describe:

_____

Do you know your highest adult weight? _____ Age _____

Do you know your lowest adult weight? _____ Age _____

How often do you weigh yourself? _____

What kind of fluctuations do you notice in your weight?

_____

_____

What would like to weigh? _____ Last time you weighed this? _____ For how long? _____

"Set point" is a weight where the body tends to stabilize with normal eating. What do you think your "set point" weight is? _____ Last time you weighed this? _____ For how long? _____

What are three words you would use to describe how you feel in your body?

_____

Circle the things you do to "check" your body:

Scrutinize myself in mirrors	Measuring tape	Picture collection
Compare my body to others	Feeling for bones/fat	Other _____

MENSTRUAL PATTERNS: If you are a person who menstruates, please answer the next five questions.

Approximate date of last menstrual period _____

What is your average weight fluctuation during your cycle? _____

Age at first menses _____ Weight at first menses _____

Do your cycles become irregular or cease with weight changes? Yes ___ No ___

If yes, at what weight? _____

Are you on birth control pills or hormone replacement therapy? Yes ___ No ___

GASTROINTESTINAL CONCERNS

Do you have problems with:

a) Constipation? Yes ___ No ___ Describe: _____

b) Diarrhea? Yes ___ No ___ Describe: _____

c) Nausea? Yes ___ No ___ Describe: _____

d) Bloated-ness? Yes ___ No ___ Describe: _____

OTHER HEALTH CONCERNS

List any medical conditions you would like me to be aware of:

_____

_____

Are any of the following true for you (circle all that apply):

get cold easily	bruise easily	tired easily	insomnia
hair falling out	night sweats	sudden hunger	

LIFESTYLE/DAY TO DAY CARE:

What percentage of your day is focused on food and weight? _____

What is your current stress level on a scale from 0-10, with 10 being high? _____

What is your usual stress level? _____

What causes you the most stress currently? _____

What helps you cope with stress?

_____

_____

How many hours do you usually work daily? _____

How many hours do you sleep daily? _____

What do you do to relax? _____

_____

How often do you drink alcohol? _____ How much per occasion? _____

How often do you use recreational drugs? _____ Describe: _____

ADVERSE LIFE EVENTS/TRAUMA

Many people experience adverse life events that impact their sense of well-being and safety, including and not limited to religious/spiritual trauma, oppression, bullying, harassment, abandonment, neglect, medical traumas, accidents, military service, historical trauma, and/or physical/emotional/sexual abuse or assault. Over the course of your life, have you had any experiences that you would like me to know about now?

_____

_____

_____

_____

Have you experienced weight-related discrimination or stigma from healthcare professionals, partners, family members or in a workplace setting?

_____

_____

_____

What else would you like me to know about you?

_____

_____

_____

_____

What do you hope to achieve as a result of working with me?

_____

_____

_____

_____

_____

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OFFICE POLICY

Welcome! I look forward to working with you to achieve the goals which motivated you to find me. The following are guidelines which will clarify my office policies.

TELEPHONE CALLS

I am available to assist you by telephone for a few minutes if you need me between sessions during the week. Just leave me a message and I will return your call as I can. I often don't pick up messages on the weekend, so please understand if you don't get a return call until Monday. You are also welcome to leave me a short message to report your progress at any time. If you need more than a few minutes on the phone, please consider setting up an extra session in person or by telephone that week.

SESSION TIME

Regular sessions are 50 minutes in length. I make every attempt to begin sessions on time and appreciate your cooperation in ending them on time.

FEES, BILLING, AND INSURANCE COVERAGE

It is preferable for me to receive payment at the time of your session. If you could have your check written before the session begins, we will be able to use the full session to your benefit. In some cases, I understand that it is necessary for me to bill you for my services. I am happy to cooperate with you in that regard. I would appreciate payment as soon as possible upon receipt of the statement. In regard to insurance, some insurance companies cover nutritional counseling services; however, many do not. If you would like, I will have a separate bill prepared for you so that you may submit it to your insurance company. Often, a letter from your doctor referring you to a nutritionist will help in obtaining coverage. If you do choose to submit an insurance claim, any reimbursement will go directly to you, as you will have already paid me directly for your session.

CANCELLATIONS

A 24-hour notice (i.e., one full business day) is required for all cancellations. With such notice, I am able to schedule someone else in your time slot. If your appointment is scheduled for a Monday, please call by Friday of the previous week (or preferably sooner) if you need to cancel the appointment. If your appointment directly follows a holiday, any cancellations must be made two days prior to the holiday (or, again, preferably sooner). If you are sick on the day of your appointment or have car trouble, we can do our session on the telephone. Unfortunately, I will have to charge you for any appointment which is canceled without sufficient notice. If, however, I am able to fill such an appointment, I will not charge you for the cancellation. Also, please do not cancel an appointment using your mobile phone, as transmission is not always reliable. If you must use a mobile phone, please ask me to call you back confirming the cancellation. I appreciate your cooperation in this regard.

CONFIDENTIALITY

Our meetings are held in strict confidence. A release form will be used to obtain permission to speak to your physician or psychotherapist.

These guidelines have been established to facilitate our work together. Please feel free to comment on them or ask any questions that you may have. I am here to meet your needs and offer you optimal care.

Sincerely,

Dana Sturtevant, MS, RD
Nutrition Therapist