Navesink Wellness Center

61 Carton Street
Rumson, New Jersey 07760
732-533-4224

Patient Information

Name: _____ Date of Birth:_____

Address: _____

_____

We routinely communicate with patients over the phone or via email to schedule and confirm appointments or to discuss specific information regarding treatment. Please indicate which telephone numbers or email addresses we can contact you on by checking the appropriate boxes.

Home Phone Number: _____ ☐

Cell Phone Number: _____ ☐

Work Phone Number:_____ ☐

Email Address: _____ ☐

Limits of Confidentiality

All information regarding patients, their treatments, diagnosis and appointments is kept strictly confidential within the confines of Navesink Wellness Center. To provide the most adequate and comprehensive treatment, patient information may be discussed amongst involved NWC practitioners. Discussion of treatment is always confined to treatment room, not in the presence of other patients.

Noted exceptions are as follows:

Duty to Warn & Protect

When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

Abuse of Children and Vulnerable Adults

If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the mental health care professional is required to report this information to the appropriate social service and / or legal authorities.

Prenatal Exposure to Controlled Substances

Mental health Care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

Minors / Guardianship

Parents or legal guardians of non-emancipated minor clients have the right to access the client's records.

Insurance Providers (when applicable)

Insurance companies and other third party payers are given information that they request regarding services to clients. Information that may be requested includes, but is not limited to, types of service, dates / times of service, diagnosis, treatment plan, description of impairments, progress of therapy, case notes and summaries.

Cancellation Policy

Due to the fact that your appointment is reserved specifically for you, it is required that any cancellation be done over 24 hours prior to the scheduled session. If you fail to cancel a scheduled appointment, we cannot use that time for another client. Consequently, you will be billed for the entire cost of the missed session. Exceptions are granted in cases of illness or emergencies. A bill will be mailed directly to all clients who do not show up for, or cancel an appointment.

Thank you in advance for your understanding and cooperation in this important matter.

_____ _____

Signature of Patient or Responsible Party Date

Nutritional Questionnaire

This brief survey is designed to gather critical information related to your nutrition status.
Please feel free to note anything pertinent to your healthy.

Name: _____ Age: _____ Date: _____

Height: _____ Weight: _____ Usual Body Weight: _____

Have you ever experienced significant weight loss, gain or loss of appetite? How much and when?

_____

How would you rate your body on a scale of 1 (completely dissatisfied) to 10 (completely satisfied) ? _____

Is there anything you would like to change about your body (physically or functionally)?

_____

Work Environment:

Occupation: _____

How many hours do you sit during the day? _____

What is your stress level at work on a scale of 1 (relaxed) to 10 (maxed out)? _____

Lifestyle:

What is your relationship status (circle one): Single Married Divorced Partnered

How many hours do you sleep per night? _____ Bedtime: _____ Wake Time: _____

What is your favorite type of exercise? _____ Least Favorite? _____

How many days per week do you exercise at a moderate intensity (hard to have a conversation)? _____

How long is each workout? _____

How supportive would you rate your friends and family of your goals on a scale of 1 (lack of support system) to 10 (completely supportive system)? _____

Medical History:

Please mark off any of the following conditions you currently have or had in the previously:

☐ Heartburn	☐ Pregnancy / Breastfeeding	☐ Depression	☐ Gastric Ulcer
☐ Hemorrhoids	☐ Colitis	☐ Pre / Diabetes	☐ Celiac Disease
☐ GI Bleeding	☐ Chronic Diarrhea	☐ High Blood Pressure	☐ Crohn's Disease
☐ Constipation	☐ Disordered Eating	☐ Hypoglycemia	☐ Hiatal Hernia
☐ Arthritis or RA	☐ Pancreatitis	☐ Kidney Stones	☐ Gallbladder Disease
☐ Gout	☐ Liver Disease	☐ Kidney Failure	☐ Anemia
☐ Drug Addiction	☐ Menopause	☐ Cancer	☐ Alcohol Addiction
☐ Migraine / Headaches	☐ PCOS	☐ Joint Pain	☐ TMJ / Teeth Grinding
☐ Bleeding Gums	☐ Dry, Flaky Skin	☐ Brittle Nails	☐ Abnormal Hair Loss

Type of Bariatric Surgery: _____ Date of Surgery: _____

Other Medical Conditions Not Listed: _____

For Women: Do you have a regular menstrual cycle? Yes No Do you have an IUD? Yes No

Are you taking any over the counter medications, birth control or antacids? Please List:

_____

Do you smoke? Yes No How much & how often? _____

Diet History:

Who is the primary cook at home? _____

Who is the primary food shopper? _____

How often do you go out to eat? _____

What is your favorite restaurant or type of food (e.g. Mexican)? _____

Have you had success with any diet plan, book or program in the past? Yes No
If so, which one? _____

Have you tried any diet plan, book or program in the past that did NOT work for you? Yes No
If so, which one? _____

Have you ever had inpatient or outpatient nutrition counseling? Yes No
Why? _____

Are you currently taking any vitamin or mineral, energy / endurance or immunity supplements (e.g. Cold-Eeze or 5 Hour Energy)? Please List: _____

How often do you use a salt shaker at meals? Always Sometimes Never

Do you eat 3 meals everyday? Yes No How Many Snacks Daily? _____

Where do you eat the majority of your meals? (i.e. at a desk, table, counter, on-the-go) _____

Do you have any food allergies or intolerances (such as lactose intolerance) ? _____

Do you have any dietary restrictions (such as vegan / vegetarian) ? _____

How often do you drink alcohol? _____ How many drinks in one sitting? _____

How much soda do you drink per day? _____ What kind? _____

How much caffeinated tea per day? _____ How much water per day? _____

What are your three favorite foods?

_____
_____
_____

What are your three least favorite foods?

_____
_____
_____

Nutritional Goals: *In your own words, why are you interested in nutrition therapy?*

1.

2.

3.