BLUEGRASS NUTRITION COUNSELING SCREENING FORM

Name:_____ Age:_____ Birthdate:_____

Biological Sex:_____ Pronouns:_____

Contact Information

Email Address:_____

Home Address (include city and zip code):_____

☐Primary Phone:_____ ☐ Secondary Phone: _____

Please check which number you would like appointment reminders sent to.

Guardian Name:_____ Address:_____

Phone:_____ Email Address:_____

Clinical Information

Height:_____ Current Weight:_____ Usual Weight:_____

Has your weight changed recently?

Increased by _____ in the last _____ month(s).

Decreased by _____ in the last _____ month(s).

If applicable, please provide growth charts from your doctor's office. Records can be faxed to 859-208-2234.

If applicable, what was the date of your last menstrual cycle:_____

Personal Information

Occupation:_____ Employer:_____

Primary Nutrition Concern(s):_____

Other Medical Problem(s):_____

Pertinent Family History:_____

Medications/Supplements:_____

Allergies:_____

Current Eating Habits:_____

Current Exercise/Movement Pattern:_____

I authorize the release of medical or other information necessary to process any claims. In the event that my insurance company will not cover nutrition services, I will be responsible for payment.

_____ _____

Signature Date