Bluegrass Nutrition Counseling Screening Form Appt Date/Time_____

PERSONAL INFORMATION

Name:_____Sex:_____Age:_____Birthdate:_____

Email:_____(OK for our use only? YES/NO)

Address (include City, State, Zip Code):_____

Phone: Primary_____ Secondary_____

Height:_____Current Weight:_____Usual Weight:_____Goal Weight:_____

Has your weight changed recently? If so, over what period of time?_____

Occupation:_____Employer:_____

Primary Nutrition Problem/Concern:_____

Other Medical Problem (s):_____

Pertinent Family History: _____

Medications/Supplements: _____

Allergies:_____Current Exercise Program:_____

Current Diet:_____

Guardian Name:_____Address:_____

Phone: Primary_____ Secondary:_____

Guardian's Email Address:_____

INSURANCE INFORMATION

Primary Insurance:_____Member ID #:_____

Phone (of Insurance Company):_____

Name of Insured:_____Birthdate:_____Phone:_____

Name of Employer:_____Phone:_____

Secondary Insurance:_____Member ID #:_____

Phone (of Insurance Company):_____

Name of Insured:_____Birthdate:_____Phone:_____

Name of Employer:_____Phone:_____

I authorize the release of any 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**