



NEW CLIENT INFORMATION

NAME:	INITIAL APPOINTMENT DATE:
Date of Birth: ___/___/___ Age: ___	___/___/___

PARENT/GUARDIAN (IF <18 YEARS OLD):

CLIENT CONTACT INFORMATION

ADDRESS:

CITY/STATE: ZIP:

HOME PHONE: CELL PHONE:

E-MAIL:

PREFERRED METHOD OF CONTACT: (CIRCLE ONE) HOME CELL CELL/TEXT E-MAIL

PARENT/GUARDIAN OR EMERGENCY CONTACT INFORMATION:

PARENT/GUARDIAN OR EMERGENCY CONTACT NAME:

ADDRESS:

CITY/STATE/ZIP:

HOME PHONE: CELL PHONE:

MEDICAL HISTORY & NUTRITION RELATED ISSUES (attach additional sheet if needed)

PLEASE CHECK BOX IF YOU HAVE/HAVE HAD ISSUES WITH ANY OF THE FOLLOWING...

- | | | |
|---|---|---|
| <input type="checkbox"/> Weight management | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Vitamin deficiencies |
| <input type="checkbox"/> Chronic dieting | <input type="checkbox"/> Thyroid disorder | <input type="checkbox"/> Menstrual irregularities |
| <input type="checkbox"/> Eating disorder | <input type="checkbox"/> Anemia | <input type="checkbox"/> Constipation/diarrhea |
| <input type="checkbox"/> Sports nutrition | <input type="checkbox"/> Gallbladder | <input type="checkbox"/> Orthopedic/joint |
| <input type="checkbox"/> Cardiovascular disease | <input type="checkbox"/> Addictions | <input type="checkbox"/> Food Allergy/lactose intolerance |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Depression/anxiety | <input type="checkbox"/> Other, please list below |

PLEASE LIST CURRENT MEDICATIONS:

PLEASE LIST VITAMINS/MINERALS/SUPPLEMENTS YOU TAKE:

WHAT IS YOUR REASON/GOAL FOR SEEKING NUTRITION COUNSELING?

DO YOU HAVE RELIGIOUS BELIEFS THAT IMPACT YOUR DIETARY INTAKE? YES NO

IF YES, PLEASE LIST RESTRICTIONS:

THE ABOVE INFORMATION IS ACCURATE TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT THIS INFORMATION IS NECESSARY FOR PROVIDING ME WITH APPROPRIATE NUTRITION GUIDANCE.

SIGNATURE CLIENT OR GUARDIAN: DATE:



NEW CLIENT INFORMATION & POLICIES

REFERRALS & RELEASE OF INFORMATION

Who referred you to Schilling Nutrition Therapy, LLC (SNT)?

Would you like SNT to communicate with the *person listed above* about your nutrition therapy progress?
YES NO IF YES, PHONE:

At times it is helpful for SNT to correspond with other members of your health care team, such as therapists, physicians, trainers, or family members (if >18). If you would like SNT and these professionals/family members to mutually share information/communicate with each other, you *must list them and sign below*. Please note that you can add to or revoke the release, in writing, at any time.

PLEASE LIST NAME, TITLE/RELATIONSHIP, AND PHONE NUMBER

NAME: _____ PHONE: _____

TITLE/RELATIONSHIP: _____

NAME: _____ PHONE: _____

TITLE/RELATIONSHIP: _____

NAME: _____ PHONE: _____

TITLE/RELATIONSHIP: _____

NAME: _____ PHONE: _____

TITLE/RELATIONSHIP: _____

NAME: _____ PHONE: _____

TITLE/RELATIONSHIP: _____

I GRANT PERMISSION FOR SNT TO MUTUALLY COMMUNICATE WITH ABOVE NAMED PROFESSIONALS OR FAMILY MEMBERS. CONFIDENTIALITY WILL BE STRICTLY MAINTAINED WITHIN THE LIMITS OF THE LAW.

SIGNATURE CLIENT _____
OR GUARDIAN: _____ DATE: _____

NOTICE OF PAYMENT POLICY

Payment is due at the time of service. SNT **does not bill insurance** but will be glad to provide any receipts/documentation you may require. Methods of payment are cash, check, Visa or Master Card.

SIGNATURE CLIENT _____
OR GUARDIAN: _____ DATE: _____

NOTICE OF CANCELLATION POLICY

SNT requires 24 hours advance notice (1 full business day) for cancellations or rescheduled appointments. Your appointment is a reservation of SNT's time. With advance notice SNT can fill that time with a client on the waiting list. If you are not able to attend your scheduled appointment, you will be charged the full appointment fee. If you contact SNT with at least 24 hours advance notice of your scheduled appointment, SNT will reschedule you for another time and there will be no charge.

SIGNATURE CLIENT _____
OR GUARDIAN: _____ DATE: _____