



### PATIENT PROFILE

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Nickname: \_\_\_\_\_ Birth date: \_\_\_\_\_ Sex: \_\_\_\_\_

**A note to my patients:** This is a confidential record of your medical treatment and will not be released, except when you have provided me with written authorization to do so. Thank you.

What goals do you have for your visit? \_\_\_\_\_

Have you ever consulted a Nutritionist or a Counselor before? yes, no (please circle)

### PRESENT HEALTH CONCERNS

Please list most important health concerns in their order of significance.	Prior diagnosis of this problem? If so, what?	Indicate past and/ or present treatment
1.		
2.		
3.		
4.		

Please list prescription medications that you are currently taking, with dosages:

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_  
4. \_\_\_\_\_ 5. \_\_\_\_\_ 6. \_\_\_\_\_

List vitamins, minerals, herbs, homeopathic remedies that you are currently taking, with dosages:

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_  
4. \_\_\_\_\_ 5. \_\_\_\_\_ 6. \_\_\_\_\_

Have you ever been diagnosed with a food allergy or sensitivity? If so, please explain. If no, do you suspect that you have one?

\_\_\_\_\_  
\_\_\_\_\_

Please list any severe or life-threatening allergies: \_\_\_\_\_

Explain: \_\_\_\_\_

What is your current body weight? \_\_\_\_\_ Do you have a weight goal in mind? \_\_\_\_\_

If yes, when is the last time you were at this weight and how long were you able to maintain this? \_\_\_\_\_

**Personal Habits**

Please circle any of the following substances that you use regularly: Tobacco - Coffee/ tea/cola – Alcohol - Recreational Drugs

Do you follow any particular diet regimens or restrictions? If yes, please describe: \_\_\_\_\_

Do you exercise regularly? Yes No What type? \_\_\_\_\_

How long? \_\_\_\_\_ How often? \_\_\_\_\_ How many hours a night do you sleep? \_\_\_\_\_

**Past History:**

Hospitalizations: \_\_\_\_\_

Date of last antibiotic round? \_\_\_\_\_ Is there a history of taking antibiotics? \_\_\_\_\_

Serious Illnesses and Injuries: \_\_\_\_\_

Date of last physical/annual exam \_\_\_\_\_ Date of last blood tests: \_\_\_\_\_

**Symptoms:**

Please circle all that relate to you.

Irritable bowel syndrome	gas, belching, fatigue after meals	Cough (unproductive)	Mood swings	Tinnitus (with normal hearing and other causes ruled out)
Skin rashes	Spastic Colon	Mental Dullness	Hoarseness	Sinus or migraine headaches
Vertigo	Post nasal drip	Muscle spasms, soreness or weakness	Asthma or asthma bronchitis	Chronic fatigue
Itchy eyelids	Fluctuating hearing loss (feels like ears are stopped up)	Forgetfulness	Chronic fatigue	Weight fluctuations/ intermittent swelling or edema
Sleep apnea or insomnia	Cardiac rhythm disturbances	Depression aggravated or worsened by food allergies	Bloating	Intermittent diarrhea, and constipation

**Social History:**

Please circle those that apply: Single Married Significant other

Do you have any children? Yes No Please list their age(s) \_\_\_\_\_

Please bring this completed intake form with you to your first appointment. Thank You!



## **GENERAL CONSENT FOR TREATMENT AND CONSENT TO USE AND DISCLOSE HEALTH AND MEDICAL INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS**

Welcome to Nutrition Northwest, Co. This handout summarizes important information that you should know about our services and provides us with your written consent for treatment/care by our licensed certified nutritionist as well as your consent to our use and disclosure of your protected health information for treatment, payment for services, and health care operations. We ask you to read it carefully, ask any questions that you may have, and then sign, date and return the form to us.

### **I. Services Offered**

Nutrition Northwest, Co., provides a variety of services related to nutritional counseling, prevention and treatment of conditions that benefit from nutritional therapy. The certified nutritionist in consultation will determine if the care needed involves resources or competencies beyond the scope of our services, and will, provide the appropriate referral, documentation, and follow-up.

### **II. Confidentiality**

Your medical records on file at Nutrition Northwest, Co., are treated as confidential records and will only be released pursuant to your authorization or as otherwise permitted or required by law. See Nutrition Northwest, Co. Health Care Components Notice of Privacy Practices. This Notice is posted on the Health Services web page [at www.nutritionnorthwest.com/hipaa](http://www.nutritionnorthwest.com/hipaa). You may also ask the certified nutritionist or administrative coordinator at Nutrition Northwest, Co. for a printed copy of this notice.

### **III. Your Responsibilities**

Patients are expected to honestly answer the Patient Intake Form and provide a full and accurate medical history to our certified nutritionist at the time of their consultation.

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Red Cedar Wellness Center  
1601 116<sup>th</sup> Ave NE Suite 100  
Bellevue, WA 98004

425.747.5282 phone  
[www.NutritionNorthwest.com](http://www.NutritionNorthwest.com)  
[Angela@NutritionNorthwest.com](mailto:Angela@NutritionNorthwest.com)

Woodinville Primary Care  
17311 135th Ave NE #A700  
Woodinville, WA 98072



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**CONSENT FOR TREATMENT/CARE**

I have read the above material regarding rights and responsibilities of the patient as it relates to the services provided by Nutrition Northwest, Co. I understand its provisions, and agree to receive services under the above conditions and I consent to treatment/care, as determined to be necessary by the certified nutritionist at the afore mentioned offices.

**CONSENT FOR USE AND RELEASE OF INFORMATION**

I give permission to Nutrition Northwest, Co. and other staff to release any information about me, my health, the health services provided to me, or payment for my health services which may be necessary:

1. For my treatment – to any physician, or other health care providers or facilities which need the information for my continued care, only with written authorization by me.
2. For payment purposes – to determine whether I am eligible for insurance coverage and if this treatment/care is authorized for payment by my insurance. This information may also be used to process an insurance claim, for billing and for collection purposes.

**Patient Name** (please print) \_\_\_\_\_

**Date of Birth** \_\_\_\_\_ **Age** \_\_\_\_\_

\_\_\_\_\_  
**Signature of Patient**

\_\_\_\_/\_\_\_\_/\_\_\_\_  
**Date**

\_\_\_\_\_  
**Signature of Parent/Guardian**  
**if patient is considered a minor in Washington State**

\_\_\_\_/\_\_\_\_/\_\_\_\_  
**Date**

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**AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION**  
**Email Correspondence Authorization**

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Patient Name

Date of Birth

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Address

Phone

By signing this form, I authorize Angela Pifer, Certified Nutritionist and Nutrition Northwest Co to communicate via:  **E-Mail** with me and with  \_\_\_\_\_(initial) other health care providers (names provided below) as necessary for my medical care and treatment.

**\*\*Complete the following only if email correspondence is being authorized:**

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Patient's Email

I authorize release of my medical care and treatment to the following health care providers:

Health Care Provider \_\_\_\_\_

Health Care Provider \_\_\_\_\_

I understand that the following types of protected health information may be used, disclosed, and retained by the health care providers as a result of the communications: (*Check all that are approved.*)

- My personal health information contained in emails and my email address;**
- Laboratory Test results, Pathology reports; and other diagnostic test results.**

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I have read and agree that e-mail messages may include protected health information about me whenever necessary. I understand that, by federal law, Angela Pifer and Nutrition Northwest Co. may not use or disclose my health information, except as outlined in this form, without my authorization. My signature on this Authorization indicates that I am giving permission for the uses and disclosures of the protected health information described above. I hereby release Angela Pifer, Nutrition Northwest Co and its employees from any and all liability that may arise from the release of information as I have directed. I understand that I have the right to revoke this Authorization at any time. If I want to revoke this authorization, I must do so in writing and address it to the person or institution named above that I am authorizing to disclose my information. I understand that if I revoke this authorization, it will not apply to any information already released as a result of this authorization. I understand that I may refuse to sign this Authorization. I also understand that the institutions or individuals named above cannot deny or refuse to provide treatment, payment, enrollment in a health plan, or eligibility for benefits if I refuse to sign this Authorization. I understand that, once information is disclosed pursuant to this Authorization, it is possible that it will no longer be protected by the federal medical privacy law and could be disclosed by the person or agency that receives it. Angela Pifer, Nutrition Northwest Co and its employees will not be liable for information lost or misdirected due to technical errors or failures.

\_\_\_\_\_ Date: \_\_\_\_\_  
Patient Signature

The following confidentiality statement is included in all e-mails between patients, physicians and nutritionist: The preceding message contains information that may be privileged and/or confidential. The information is intended for the use of the designated recipient only. If you have received this email in error, please be advised that any disclosure, copying, distribution or other use of the contents is prohibited. If you are not the intended recipient, please contact the sender by reply e-mail and destroy all copies of the original message.

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