Dear Patient and Family:

Welcome to the Nutrition Programs of the Metabolic Health Center! Our staff of registered dietitians are here to provide you with nutrition counseling to help you successfully manage your condition.

Please note that your insurance company will be billed for these services unless other arrangements were made before your scheduled appointment. You will be responsible for any non-covered benefits, unmet deductible, co-payment, or co-insurance. We have found that most insurance companies do not cover nutritional counseling. NOTE: Should you have any questions regarding insurance coverage, please contact your insurance company first and then follow up with us if you have more questions. If you want to check coverage with your insurance company, please let them know that we are a hospital outpatient facility.

Once we receive a completed referral from your doctor, we will call to schedule your appointment. The appropriate paperwork should be filled out in full and brought with you the day of your first appointment together with your photo identification. If you are unable to complete the paperwork before your scheduled appointment, please call us to reschedule.

Kindly give us at least 24 hour notice if you are unable to keep this appointment. This will allow us to give better care to all of our patients because we consistently have patients waiting for appointments who could then be seen at an earlier time. (You also may be asked to reschedule your appointment if you arrive 10 minutes late.)

Thank you for your consideration and cooperation. We look forward to seeing you.

Respectfully,

TMH PP Metabolic Health Center Administration
Pediatric Nutrition Questionnaire

Patient Name_____________________________________________________ DOB __________________ Race________________

Mailing Address______________________________________________________________________________________________

Please specify any religious/cultural or personal health beliefs that you would like us to consider as we help you develop your child’s nutrition care plan:
____________________________________________________________________________________________________________

What language do you prefer using in discussing your child’s health care?  ☐ English  ☐ Other:____________________________

Parent/Guardian Information:

Name____________________________________Relationship_______________________ Occupation_______________________
Phone: Home______________________________Work_____________________________ Cell_____________________________

Name____________________________________Relationship_______________________ Occupation_______________________
Phone: Home______________________________Work_____________________________ Cell_____________________________

Child lives with (please give name, age, and relationship):
__________________________________________________________________________________________________________

Child’s school or daycare _______________________________ Grade _________ Hours at school___________________________

Does your child have any food or medication allergies? ☐ No  ☐ Yes  If yes, please specify:\________________________________________

Does your child or any other family member have any of the following health problems?

- Anxiety/depression ☐ No  ☐ Yes  If yes, who?______________________________
- Asthma ☐ No  ☐ Yes  If yes, who?__________________________________________
- Celiac disease ☐ No  ☐ Yes  If yes, who?____________________________________
- Constipation/diarrhea ☐ No  ☐ Yes  If yes, who?______________________________
- Diabetes ☐ No  ☐ Yes  If yes, who?__________________________________________
- Heart disease ☐ No  ☐ Yes  If yes, who?____________________________________
- High cholesterol ☐ No  ☐ Yes  If yes, who?__________________________________
- High blood pressure ☐ No  ☐ Yes  If yes, who?______________________________
- Kidney disease ☐ No  ☐ Yes  If yes, who?__________________________________

Other medical information that may help us better know your child: ________________________________________________

___________________________________________________________________________________________________________________________________________
Social History:

Please describe any personal or family events or concerns that we should be aware of, such as divorce, moving, school problems.

____________________________________________________________________________________________________________

____________________________________________________________________________________________________________

Does your child use alcohol, tobacco, or recreational drugs? ☐ No ☐ Yes If yes, please explain

____________________________________________________________________________________________________________

Are you or your child in a situation in which you fear for your safety? ☐ No ☐ Yes

Exercise and Activity:

List your child’s sports or extracurricular activities: ______________________________________________________________

List any physical limitations of your child: ______________________________________________________________

Growth History:

Child’s birth weight ________ Child’s birth length ________

Mother’s weight ________ Mother’s height ________ Father’s weight ________ Father’s height ________

Please describe any changes or concerns about your child’s growth pattern: ______________________________________________

____________________________________________________________________________________________________________

Do you have any concerns about the food choices of your child or family? ☐ No ☐ Yes If yes, please explain ___________________

____________________________________________________________________________________________________________

Are you or any members of your family currently on any type of meal plan or diet? ☐ No ☐ Yes If yes, please describe _______________________________________________________________________________________

Who does most of the cooking and grocery shopping in your home? _______________________________________________________

Are there any food practices that we should know about? (such as vegetarian, no pork) ______________________________________

Child’s favorite beverages: _____________________________________________________________________________________

Usual Daily Schedule:

Where is the child usually? (school, home, grandma’s, etc)  Sit down family meal or eaten “on the run”?  Typical Foods

Breakfast

Time ________

Lunch

Time ________

Dinner

Time ________

Snacks: What? ___________________________________________ When ____________________

Signature of person filling out form ___________________________________________________________ Date ____________________

Relationship to patient ___________________________
PATIENT MEDICATION and SUPPLEMENT LIST

Name:__________________________________  DOB:______________   Physician:____________________________
Pharmacy:____________________________________________________________________________________
Medication Allergies:__________________________________________________________________________

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Reviewer Signature/Date/Time

________________________________________     _________________________________________  ____________
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*** Notice to Patient** Keep an updated medication list with you at all times in case of emergency situations. Update the information when medications are changed or discontinued. If you have been seen for a consult, give a copy of your medication list to your Primary Care Physician
rev. 0514;05/2017