The Outpatient Nutrition Programs of the
TMH Physician Partners- Metabolic Health Center
2633 Centennial Blvd, Suite 100
Tallahassee, Fl 32308
850 431-5404/FAX 850 431-4838

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: _____

Patient Name_____ **DOB** _____

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_____
Relationship to patient_____ Date_____

For Office Use Only
ICD-10- Code: _____

PATIENT MEDICATION and SUPPLEMENT LIST

Name:_____ DOB:_____ Physician:_____
Pharmacy:_____
Medication Allergies:_____

Medication name	Dose	Taken by	Frequency (times per day)
		□ mouth □ injection □ inhaled □ _____	
		□ mouth □ injection □ inhaled □ _____	
		□ mouth □ injection □ inhaled □ _____	
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Reviewer Signature/Date/Time

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

*** 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
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