Nutritional Counseling Intake Form

Name ____ Date____________ Date of Birth ______________

Address____ Phone: (cell) ___________ (home) _____________

____ Email: ___________________________ Sex M F

Health History (Include date)

Height ______ Weight _______ Wt at age 20 _________ Currently Pregnant: YES NO Breastfeeding: YES NO

How do you rate your health? Poor _____ Fair _____ Good ____ Excellent ____

Childhood Illnesses or Injury ____

Adult Illnesses, Injury or Disease____

Operations or Hospitalizations ____

List any chronic pain, type and severity ____

Have you taken repeated courses or been on antibiotics for long periods of time? YES NO Reason___________________

List date of last: Routine Physical Exam __________ Dental Exam __________ Eye Exam_________

List nutrition-related labs with date (i.e. Vit D levels, blood glucose, blood pressure, cholesterol, hemoglobin, CRP) or include copies of lab reports____

List allergies (environmental, food, medication etc)____

List major health problems of family members____

____

Rate your stress level from 1 to 10 1 2 3 4 5 6 7 8 9 10 (with 1 being no stress, and 10 unbearable stress)

List causes of stress ____

Do you use any relaxation techniques on a regular basis? _______ What types? ___________________________

How often do you experience of the following:

Anxiety	never rarely frequently constantly	Eating disorder	never rarely frequently constantly
Depression	never rarely frequently constantly	Substance abuse	never rarely frequently constantly
Other_______________________________			never rarely frequently constantly

Medications and Supplements

List all prescription and over-the-counter medications that you currently take (include the dosages): __________________

____

List all vitamins, minerals, supplements, and herbs that you take: ____

____

Lifestyle

Marital Status: Single   Married   Partnered

Occupation ____________________________ Work Hours ______________________ Children's Ages _______________

Have you ever smoked or used any tobacco products?   Yes   No   Type   Amount   How Long   Date Quit

_____________ _________ ___________ ________

Do you know, or is it likely that you have been exposed to higher than normal levels of pesticides, herbicides, lead, arsenic treated wood, mercury, asbestos, nerve agents, industrial chemicals, dry cleaning solvents or other toxic substances?

YES NO Name_____________________________ How exposure occurred __________________________________

List the amount of the following beverages consumed:

Regular coffee ______ cups/ day   Regular soda ______ cans/day   Beer or Wine ____ drinks /week

Decaf coffee _____ cups/ day   Diet soda _____ cans/ day   Mixed Drinks ____ drinks/ week

How many times per week do you do the following exercise?

Aerobic training _____   Strength training _____   Stretching _____

How many hours of sleep do you usually get per night? ______ Do you feel this is sufficient? ______

Do you have any of the following sleep problems?

Trouble falling asleep _____   Frequent waking during the night_____   Wake up too early _____   Nightmares _____

Frequent nighttime urination _____   Noise disturbances _____   Severe snoring/sleep apnea _____   Restless legs _____

On a scale of 1 (poor) to 5 (excellent) rate you overall energy level   1   2   3   4   5

On a scale of 1 (not ready) to 5 (very ready), how ready are you to make lifestyle changes?   1   2   3   4   5

On a scale of 1 (not at all confident) to 5 (very confident), how confident are you to make lifestyle changes?   1   2   3   4   5

List in order of importance the primary health concerns that you would like to address with nutritional counseling

1. ____

2. ____

3.____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge receiving a copy of the Notice of Privacy Practices of In-Tune Wellness/Sara Ruiz RDN, LD on _______________

Printed name of patient ____

Printed name of authorized representative (if applicable) ____

Signature of patient or authorized representative____

Financial/Cancellation Policy/Assignment of Benefits/ Authorization to Bill Insurance

Payment is due at the time of service for labs, co-pays, deductibles, and non-covered services.

Insurance: In-Tune Wellness is an in-network for Blue Cross, Medica, United Healthcare, Preferred One, Select Care/Labor Care, Aetna and Minnesota Care (Medica and Blue Cross plans only).

Coverage for nutrition counseling varies depending on each plan contract. In-Tune Wellness will provide an insurance verification of benefits if insurance information is provided at least 2 business days before your appointment. Insurance companies reserve the right to approve or deny a claim after the visit when the claim is submitted to them. Specialty lab services are not covered by insurance and payment is due upon test order.

Nutrition Counseling Fee Schedule		**Discount Rate for Payment at the Time of Service**	
Initial Consults (60-90 minutes)	$220/hr	Initial Consult:	$120/hr
Follow-up Consults (45-60 minutes)	$180/hr	Follow-up Consults:	$90/hr

- Patients are responsible for non-payment by their insurance. Accounts unpaid by the insurance greater than 90 days will be billed to the patient.
- There is a $35 NSF fee on all returned checks.
- Outstanding balances greater than 120 days will be turned over to a collection agency unless arrangements have been made in writing.

I authorize Sara Ruiz RDN/In-Tune Wellness LLC to bill my insurance company for services rendered and I agree to have any checks or payments made my such insurance company payable to:

In-Tune Wellness LLC
2110 Fremont Ave E
Saint Paul MN 55119

Cancelation Policy

No charge for cancellations made greater than 48 hours before scheduled appointment time. A fee may be charged for no shows or cancellations less than 48 hours.

I agree to the above financial and cancellation policies for Sara Ruiz RDN/ In-Tune Wellness LLC. I the undersigned have read, understand and accept the information and conditions specified in this agreement.

______________________	______________________	__________
Name Printed	Patient Signature	Date
______________________	______________________	__________
Authorized Representative (if patient is a minor or has authorized representative)	Authorized Representative Signature	Date

AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION

Authorization for Use/Disclosure of Information:

Patient Name_________________________________ Date of Birth _________________

Physician _____________________________________ Phone ______________________

I voluntarily consent to authorize my health care provider to use or disclose my health information during the term of this Authorization to the recipient(s) that I have identified below.

Recipient: I authorize my health care information to be released to the following recipient:

In-Tune Wellness LLC
2110 Fremont Ave E
Saint Paul, MN 55119
Ph: 612-354-6625
Fax: 612-246-3978

Purpose: I authorize the release of my health information for the following specific purpose:
___________Nutrition Counseling/Medical Nutrition Therapy________________________.

Information to be disclosed: I authorize the release of the following health information:

- ❑ Visit notes, lab results and diagnosis lists relating to any medical history, mental or physical condition and any treatment received by me. This excludes HIV test results, outpatient psychotherapy notes and drug and alcohol treatment records.

Term: I understand that this Authorization will remain in effect:

- ❑ For one year OR
- ❑ Until the following event occurs:____

____ ___________________
Signature Date

If individual is unable to sign this authorization, please complete the information below:

________________________ ______________________ ___________________
Name of Guardian/Representative Legal Relationship Date

For eClinicalWorks users, electronic referrals and records can be sent securely via the free P2POpen tool.

Symptom Survey

Name: ______________________________ **Date:** ______________________

To fill out this form, you will ask yourself if you experience the following symptoms and if so, how severe.

To start, first determine if you have recently experienced the symptom. If you have not, write a “0” in the corresponding field. If you have, determine how often you experience this symptom: occasionally (less than 2 times in a week) or frequently (2 or more times per week). Then decide whether or not the symptom is sever or not severe.

Use the SCALE OF SYMPTOM POINTS listed below to write the appropriate score in the corresponding symptom for EVERY symptom listed. Lastly, total points for each category. Then add up all category totals to find the Grand Total.

SCALE OF SYMPTOM POINTS:		Grand Total:
0 = Do Not Suffer From This Ever or Almost Ever 1 = Suffer OCCASIONALLY (less than 2 times per week), is not severe 2 = Suffer FREQUENTLY (2 or more times per week), is not severe 3 = Suffer OCCASIONALLY and is severe 4 = Suffer FREQUENTLY and is severe	___ Initial Report ___ Follow-up	

	CONSTITUTIONAL		**NASAL/SINUS**		**MUSCULOSKELETAL**
	Fatigue (sluggish, tired)		Post Nasal Drip		Joint Pains/Aching
	Hyperactive (nervous energy)		Sinus Pain		Stiff Joints
	Restless (can’t relax/sit still)		Runny Nose		Muscle Aches
	Sleepiness During Day		Stuffy Nose		Stiff Muscles
	Insomnia at Night		Sneezing		
	Malaise (feeling poorly)				
	TOTAL (0-20)		**TOTAL (0-20)**		**TOTAL (0-20)**
	EMOTIONAL/MENTAL		**MOUTH/THROAT**		**DIGESTIVE**
	Depression (feelings of hopelessness)		Sore Throat		Heartburn/Esoph.Reflux
	Anxiety (**vague fears, uneasiness)**		Swollen Throat		Stomach Pains/Cramps
	Mood Swings (**rapid changes)**		Swelling of Lips/Tongue		Intestinal Pains/Cramps
	Irritability		Gagging/Throat Clearing		Constipation
	Forgetfulness		Lesions ("Canker Sores")		Diarrhea
	Lack of concentration/focus				Bloating Sensation
	TOTAL (0-24)		**TOTAL (0-20)**		Gas (of Any Kind)
	HEAD/EARS		**LUNGS**		Nausea, Vomiting
	Headache (any kind)		Wheezing (Asthma or Asthma-like Symptoms)		Painful Elimination
	Earache		Chest Congestion		**TOTAL (0-36)**
	Ear Infection		Non-Productive Coughing		
	Ringing in Ear		Productive Coughing		
	Itchy Ears				
	TOTAL (0-24)		**TOTAL (0-20)**		
	SKIN		**EYES**		**WEIGHT MANAGEMENT**
	Blemishes, Acne		Red or Swollen Eyes		Fluctuating Weight
	Rashes, Hives		Watery Eyes		Food Cravings
	Eczema		Itchy Eyes		Water Retention
	“Rosy” Cheeks		Dark Circles" or "Baggy"		Binge Eating or Drinking
	TOTAL (0-16)		**TOTAL (0-20)**		Purging (all methods)
	CARDIOVASCULAR		**GENITOURINARY**		**TOTAL (0-20)**
	Irregular Heartbeat		Increased Urinary Frequency		
	High Blood Pressure		Painful Urination		
	TOTAL (0-8)		**TOTAL (0-20)**		

Comments:

Sara Ruiz RDN, LD, CLT
612-354-6625 phone
612-246-3978 fax

In-Tune Wellness LLC
Nutrition Counseling

In-Tune Wellness LLC
www.intunewellness.net
sara@intunewellness.net

Food Intake Record

	Monday _____/_____	Tuesday _____/_____	Wednesday _____/_____
Breakfast			
Snack			
Lunch			
Snack			
Dinner			
Snack			
Water			
Exercise			
Sleep			
Symptoms			

Name: ______________________________

In-Tune Wellness LLC
Nutrition Counseling

	Thursday ______/______	Friday ______/_______	Saturday ______/______	Sunday ______/______
Breakfast				
Snack				
Lunch				
Snack				
Dinner				
Snack				
Water				
Exercise				
Sleep				
Symptoms				

IN-TUNE WELLNESS L.L.C.
SARA RUIZ, RDN, LD

NOTICE OF PRIVACY PRACTICES (Effective date: 1/1/21)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

OUR LEGAL DUTY AND COMMITMENT TO PRIVACY

We are committed to maintaining the privacy of your protected health information ("PHI"). We are required by law to maintain the privacy of your PHI, provide you with this Notice of Privacy Practices and notice of our legal duties regarding your PHI. We are also required to follow the practices described in our Notice of Privacy Practices currently in effect.

If you have any questions or complaints, please contact: Privacy Official/Contact Person: Sara Ruiz

IN-TUNE WELLNESS LLC

2110 Fremont Ave E, Saint Paul MN 55119

612-354-6625, sara@intunewellness.net

USES AND DISCLOSURES OF HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS ("TPO")

We may use or disclose PHI about you for our TPO, including for example:

- For treatment purposes (such as sharing information about your care with members of our staff to assist in your treatment or care, or with the physician or hospital that referred you to us, as part of efforts to coordinate your follow-up care),
- For payment purposes (such as verifying your insurance coverage or providing information needed for your health insurance plan to cover and pay for the claim for services that we provide to you)
- For health care operations (such as our administrative activities, activities to enhance the care that we provide to our patients and their satisfaction with our services, and activities to help make sure that we comply applicable law).

We may also disclose your PHI for treatment activities of other health care providers, for payment activities of other health care providers, payors or health care clearinghouses, or for the health care operations of one of those entities if we and that entity each have (or had) a relationship with you and the PHI relates to that relationship.

OTHER USES AND DISCLOSURES WITHOUT YOUR WRITTEN AUTHORIZATION

We may use or disclose PHI about you without your authorization for several other purposes required or permitted by law. Subject to certain requirements, we may use or disclose your PHI without your authorization as follows:

- to you upon request or as required by law;
- when required by the Secretary of the Department of Health and Human Services;
- for public health activities (such as reporting information to agencies authorized by law to collect information for purposes of preventing or controlling diseases, injuries or disabilities; preparing reports to the FDA; maintaining vital health records such as for births and deaths, etc.);
- for face to face communications that we make with you regarding products or services;
- to funeral directors, coroners and medical examiners;
- for purposes of organ, eye or tissue donation;
- for health oversight activities authorized by law (such as civil or criminal investigations, audits, licensure and disciplinary proceedings, etc.);
- for law enforcement;
- for specialized governmental functions (e.g., military operations; national security);

- to your personal representatives;
- for certain incidental uses or disclosures;
- to our business associates;
- to provide gifts of nominal value to you or your family;
- to correctional institutions if you are an inmate
- to help prevent or control communicable diseases;
- to your employer in limited circumstances, typically related to work place injuries or medical surveillance;
- for reporting abuse, neglect or domestic violence;
- for auditing purposes;
- for certain research studies;

for workers' compensation purposes; and

- for emergencies or disaster relief;
- to persons involved in your care or payment related to your care;
- for notification purposes with respect to your care, condition, location or death.
- for judicial and administrative proceedings (such as in response to court orders or discovery requests);
- to avoid a serious threat of harm to health and safety;

We may also contact you about appointment reminders, treatment alternatives or for fundraising purposes. In any other situation, we will ask for your written authorization before using or disclosing any of your PHI. If you sign an authorization to use or disclose information, you can later revoke that authorization to stop further uses and disclosures.

INDIVIDUAL RIGHTS

In most cases, you have the right to look at or obtain a copy of PHI that we maintain about you. We may charge a fee for costs related to your request. We may, under certain circumstances, deny your request but if we do, you can obtain a review of that denial by another licensed health care professional that we designate.

You also have the right to receive an "accounting," which lists certain instances when we have disclosed PHI about you for reasons other than treatment, payment, or health care operations. The request can cover a time period no longer than six years from the date of disclosure. Your first request in a 12-month period is free. After that, we may charge for costs related to additional requests.

If you believe that information in your record is incorrect, or if important information is missing, you also have the right to request that we correct the existing information or add the missing information. We have the right to deny such a request under certain circumstances.

You have the right to request that your health information be communicated to you in a confidential manner such as asking that we contact you at work rather than at home.

You may request that we restrict how we use or disclose information about you for treatment, payment, or health care operations or to persons involved in your care (except when specifically authorized by you, when required by law, or in emergency circumstances). We will consider your request for such restrictions, but are only bound by them if we agree to them.

To exercise any of the rights described above, please make a request in writing to our Privacy Official/Contact Person listed on page one of this Notice.

CHANGES IN OUR NOTICE OF PRIVACY PRACTICES

We may change our privacy practices at any time and the new terms shall apply to all PHI about you that we have at the time of the change and to all PHI about you that we maintain in the future. If we make any material changes, we will change our Notice of Privacy Practices and post it in the waiting area of our office. The changes will not take effect until they are reflected in a revised Notice of Privacy Practices. You can request a copy of our Notice of Privacy Practices at any time. If this Notice of Privacy Practices was sent to you electronically, you have the right to obtain a paper copy upon request. For more information about our privacy practices, contact our Privacy Official/Contact person listed on the first page of this Notice.

COMPLAINTS

If you are concerned that we have violated your privacy rights, you may contact the Privacy Official/Contact Person listed on the first page of this Notice. You may also send a written complaint to the Secretary of the United States Department of Health and Human Services. You will not be retaliated against for filing a complaint.