Synergy Integrative Medicine

Nutrition Intake Form

Name____ Date of Visit_________________________

Address______________________________________ City/State/Zip_______________________

Phone # (best)________________________ Email_____________________________________

Age_______ Date of Birth________________ Gender (circle): M / F

Current height___________________________

Current weight___________________________

Goal weight ______________________________

Have you had a recent change in your weight?

Explain____

Occupation:____

How did you hear about the nutritional services at Synergy?

____

Primary Care Provider:____

Other MD
Specialistist/Pracitioners:____

What are your most important health goals?

1. ____

2. ____

3. ____

EXERCISE: Do you exercise? ________________ If so, how may times a week?__________________

For how long per session?____________

Method of exercise:____

STRESS:
When I am stressed, I . . .
____

SLEEP:

Average amt of sleep @ night______________ Bedtime___________ Wake up_________

Do you fall asleep easily? Y / N

Do you wake often during the night? Y / N

Do you wake feeling rested? Y / N

Please list any allergies/sensitivities____

What medications/supplements are you taking?

Name	Dosage	Reason for taking

Nutrition/Food Questionnaire

On a scale of 1-10 (10 being extremely healthful) how do you rate your diet: ____________________

What foods do you crave:

____

____

What foods do you avoid and why:

____

____

____

Do you eat breakfast: Y / N

Have you made recent changes in your diet?

Explain____

How many of the following to do have **per day/week?**

______________alcohol ______________fruit juice

______________sports drinks ______________diet soda

______________water ______________regular soda

______________coffee

How many times do you eat a non-home-cooked meal per week? ________________________________

How many times do you eat fast food in a typical week?_______________________________________

Do you snack during the day? Y / N If yes, on what?

____

____

Please describe any current dietary restrictions that you may have?

____

Do you eat when you are:

Bored Y / N

Stressed Y / N

Not hungry Y / N

Do you read food labels? Y / N

Do you do the majority of food shopping and cooking in your house? Y / N

Food Type	I eat these foods (check one)		
	Daily	Weekly	Rarely
White flour products (bread, pasta, pastry)			
Refined sugar products (cereal, soda, candy)			
Artificial sweeteners			
Trans fat (fried foods, margarine, pastries)			
High salt foods (chips, canned soup, cheese)			
Highly processed foods (instant/frozen meals)			
Red meat/pork			
Eggs			
Dairy			
Poultry/Fish			
Fruit Juice			
Green leafy vegetables			
Starchy vegetables (potato, yam, corn, squash, beets)			
Whole grains (brown rice, oatmeal)			
Beans/legumes			
Nuts/seeds			
Olive oil			
Water or herb decaf tea			

What has worked/not worked for weight loss/maintenance in the past?

Medical Appointment Cancellation Policy

Dear Patient,

Synergy Integrative Medicine strives to render excellent medical care to you and all of our patients. In order to be consistent with this philosophy, Synergy uses an appointment system that sets aside time for a patient dependent on that patient's need. When you do not show up for your appointment or notify us of your inability to keep your appointment at least 24 hours in advance, the time that has been allotted for your visit cannot be used to treat another patient and is time lost to our office. With that in mind and in order to have time available for all patients, a Medical Appointment Cancellation Policy has been put into place.

Our policy is as follows:

We request that you please give our office a 24 hour notice in the event that you need to reschedule your appointment. This also makes it possible to reschedule your appointment more efficiently. If a patient misses an appointment and does not contact us with at least a 24 hour notice, we consider this to be a missed appointment, "No Show, No Call", and the following fees will be accessed:

BHRT follow up appointments (30 minutes)	$100.00
BHRT 1 year follow up appointments (1 hour)	$175.00
Wellness follow up appointments (30 minutes)	$100.00
Wellness 1 year follow up appointments (1 hour)	$150.00

As a courtesy, we do make reminder calls for appointments. If you do not receive your message or we have incorrect information, the cancellation policy will still be in effect.

If you have any questions regarding this policy, please let our staff know and we will be glad to clarify any questions you may have.

We thank you for your patronage.

I have read and understand the Medical Appointment Cancellation Policy of the practice and agree to be bound by its terms. I also understand that this notice may be changed at any time by the practice.

______________________________ ______________________________

Printed Name of the Patient **Relationship to Patient (if patient is a minor)**

______________________________ ______________________________

Signature of Patient or Responsible Party **Date**