The Portland Clinic

Welcome to Nutrition Services at The Portland Clinic

We are looking forward to seeing you at your Nutrition Consult appointment, which will last 45-60 minutes.

Before your Nutrition Consult, please complete the 2 following steps.

New Patient Questionnaire and Food Record Form

Complete the attached questionnaire and three-day food record form and bring it to your appointment. Keep the food/beverage record for three of your *usual* days. If you get this too late to keep a 3-day food record, do as many days as you can and then bring a list of the foods that you eat routinely.

Check with your insurance company

Your insurance policy may or may not cover dietitian services or medical nutrition therapy. Policies differ greatly even within one insurance company.

Here are questions to ask your insurance representative:

1) Does my policy cover **medical nutrition therapy** or the services of a dietitian (code 97802 and 97803)? Insurance companies speak in code so they may need these code numbers to answer your question. They may also want to know the reason (diagnosis) for which you will be seeing the dietitian.
2) If your policy includes these services, are there any limitations to the diagnosis covered or the number of visits?
3) Be sure to ask about your deductible and copayment.

If you need to reschedule or cancel your appointment.

We have reserved an appointment time for you. If you must change it, please call the appointment office at 503-223-3113 at least 24 hours before your appointment.
If you have a Monday appointment, please call by Friday morning. If you cancel with less than 24 hours' notice (except in emergencies), you may be charged for the appointment.

New Patient Nutrition Consultation

Last name:________________ First name:________________

Birthdate________________ Appointment date:________________

Reason for seeing the dietitian:____

____

Please check any symptoms you are currently experiencing:

	Gastro-intestinal issues	**Eating Behavior**
❑ Unexplained weight loss	❑ Heartburn	❑ Binge eating
❑ Unexplained weight gain	❑ Stomach/abdominal pain	❑ Boredom eating
❑ Change of appetite	❑ *Excess* gas	❑ Eating changes with depression
❑ Difficulty chewing	❑ Diarrhea/constipation	❑ Eating changes with stress
❑ Difficulty swallowing	❑ Nausea/ Vomiting	❑ None of the above

Height:_______Weight:________ Desired Weight:___________

List any food allergies or intolerances:____

____

Are you currently using any special diet? ❑ no ❑ yes, *if yes, describe* ________________________

____

List any previous diets you have used:____

____

Frequency of eating in a restaurant/food cart/ fast food/food delivery/ other's homes/etc.?

___times per ❑ day **or** ❑ week **or** ❑ month Usual places________________________________

____

List beverages that you drink regularly:____

____

____

How much alcohol do you drink? Number of drinks: ____per ❑ day ❑ week ❑ month ❑ year

Circle all that apply: beer/wine/hard cider or hard lemonade/liquor/mixed drinks/other

Please list anything in your life that affects your eating habits___________________________________

____

____

Do you exercise? ❑ no ❑ yes *if yes describe type & amount*_____________________________________

____

List any vitamins/minerals /herbal or other nutritional supplements that you take regularly that are not already listed on your electronic medication list: *(include amount if known)*

____

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____

With whom do you live?:____

and ages of children *at home* ____

Your occupation:____

List any goals that you have for your health: ____

____

____

____

List any specific questions that you want to address or other information that you want to provide:

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