cascade
HEALTH SOLUTIONS

NUTRITION EDUCATION

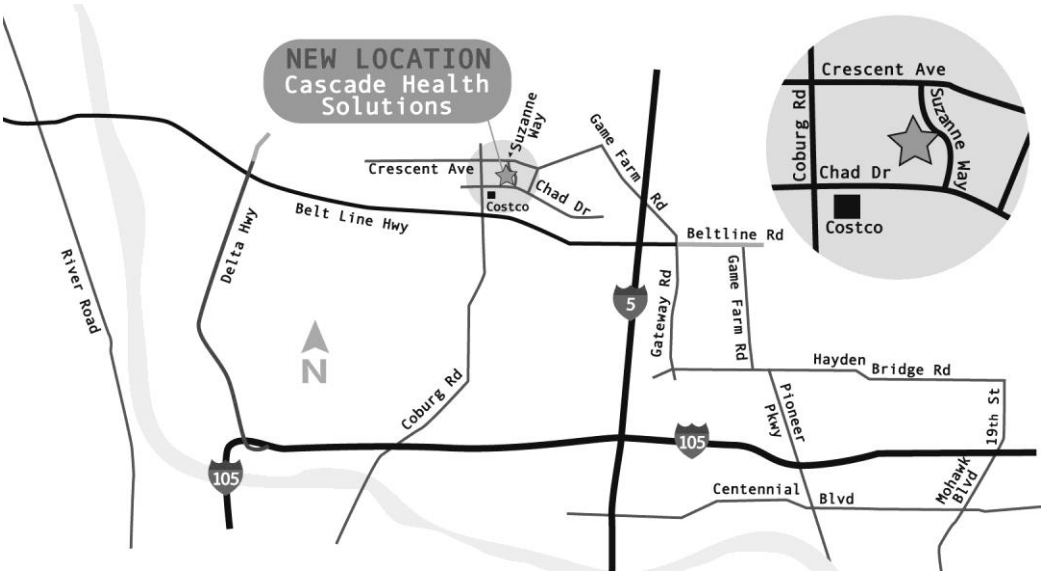
Thank you for choosing Cascade Health Solutions. We have you scheduled on.

_____at_____with_____

We have enclosed a patient registration, questionnaire form. Please fill out and bring with you to your appointment. If you have further questions regarding our services you can reach us at **228-3020**. We look forward to meeting you.

Address: 2650 Suzanne Way, Suite 160 (first floor, across from the elevator)
Eugene, Oregon 97408

Directions to our office



Please bring to your appointment:

- Completed registration and questionnaire
- Insurance card(s)
- Food Record

Cascade Health Solutions
Nutrition Education Registration

Date:_____

Name: _____**Name you prefer to be called:**_____
Last **First** **Initial**

Address: _____**City**_____**Zip**_____

Social Security: _____**Birthdate:**_____**Age:**_____

Phone: Hm:_____**Wk:** _____ **Cell:** _____

Emergency Contact Information of Friend or Relative Not Living with You:

Name: _____**Phone:**_____**Relationship:**_____

Insurance Information (please bring your cards to your appointment)

Primary Insurance: _____ID#_____

Secondary Insurance: _____ID#_____

Marital Status Married Single Widowed Seperated/Divorced **Spouse/**significant other:_____

Employer:_____**Occupation:**_____

Retired: N Y , if yes, when_____

Referring Physician: _____**Opthalmologist:** _____

MEDICATION: List ALL current medication, vitamins & minerals. (List name, amount and time you take them)

- **Do you have?** (circle all that apply)

Neuropathy (nerve disease)	Retinopathy (eye disease)	Nephropathy (Kidney disease)	Heart Disease
High blood pressure	Foot problems	Frequent infections	High or low blood sugar
High Cholesterol	Irritable Bowel	Cancer current or history	Arthritis
Fibromyalgia	Chrones/Colitis	Reflux	Sleep Apnea

Other:_____

- **Special Needs** (circle all that apply)

Hearing Reading Speech Writing Vision Mobility Language

Family and Personal Information (circle any that apply)

- Living arrangements: Alone Spouse/Partner Family
  Friends Other: _____
- Supportive people in your life:_____
- Language spoken: English Spanish Other:_____
- Hobbies:_____

Habits (circle and comment as needed)

- Do you smoke or chew? yes packs per day_____ quit in _____ ☺
- Do you use alcohol? No yes daily / weekly Amount: _____

Activity (circle all that apply)

Do you exercise regularly? Yes No if yes, what type?_____

How often?_____ How long?_____

Do you have any physical limitations, restrictions on exercise? If so, please list:

Nutrition

- Height_____ Weight:_____ Recent weight change:_____
- Do you follow a special diet? No Yes What?_____
- Any previous nutrition education? No Yes For what? _____
  When/Where:_____
- Any special nutrition needs/allergies/intolerance's? _____
  What happens?_____
- Who prepares the food (circle all that apply) Self Family Other Eat out: _____X/week
- Do you have any difficulty chewing or swallowing food or liquids? Yes No

- **Are you pregnant?** Yes ___ No____ If yes, date due: _____
- **Who is in charge of your health?** (Circle all that apply)

  Myself Family Doctor Other

- **Current concerns** (Circle all that apply)

  Family Financial Health Work

What questions or concerns do you have about nutrition and your diet?

Food Record:

If you are filling this out prior to your session with the dietitian, please take some time to keep a food diary. Be as specific as possible; include the time you ate, the food, and amount as well as any condiments and drinks. If you are filling this out the day of your appointment, please take some time to write down a basic idea of what you eat on the attached sheet.

Children and Adolescents

- Do you eat school lunch or take lunch to school? _____
- Do you eat at friend's houses, childcare, or other places besides home?
  _____
- Do you prepare food for yourself? No Yes
- Do you feel pressure to: ___**eat more food** ___**eat less food** than you would like?
- How much time per day do you spend watching TV or playing video games?

Cascade Health Solutions

AUTHORIZATION FORSERVICES

The Patient, Parent, or Legal Guardian:

1. Requests and voluntarily consents to treatment by the Cascade Health Solutions.
2. Understands that the agency and his/her personal physician (as required by law), will coordinate and plan care and treatment with the patient.
3. Authorizes release of all medical records, health, and statistical information to other medical providers, my insurance company, authorized party responsible for my healthcare charges, federal and state agencies, and other authorized auditing/review agencies. Ongoing statistical information may be compiled and released to meet regulatory guidelines.
4. Understands that the medical record may contain information specific to drug/alcohol abuse and/or addiction, and/or to psychiatric conditions, and/or HIV testing results, and/or HIV positive diagnosis, and/or genetic testing.
5. Confirms review and receipt of the following: Patient Bill of Rights and Responsibilities and the Cascade Health Solutions brochure and information packet.
6. Certifies that information given to the agency in applying for Medicare or insurance coverage is correct.
7. I authorize payment of medical benefits to CHS for services.
8. Acknowledges receipt of a copy of the Cascade Health Solutions Notice of Privacy Practices that describes how my health information may be used and shared, and how I may obtain access to my health information. I understand that Cascade Health Solutions has the right to change this Notice at any time. I may obtain a current copy of the Notice by contacting the Privacy Officer at 541-228-3009. By signing below, I acknowledge that I have been provided a copy of the Notice of Privacy Practices.
9. I understand the following limits apply in terms of Cascade Health Solutions benefits covered by my health insurance company. I understand insurance benefits are not guaranteed. The undersigned accepts full responsibility for payment of non-insurance covered services rendered to the patient. I understand that it is my responsibility to notify CHS of any changes in my insurance while receiving services.

_____ _____

Print Name Patient or Patient's Representative Signature

_____ _____

Date Relationship to Patient

_____ _____

Witness Reason Why the Patient was Unable to Sign