Chrissy@NutritionLifestyleEducation.com / Mobile: 480.332.8127

New Patient / Client Form

Name _____ Date of Birth _____

Phone (best number to reach you at) _____

Email address _____

Mailing address _____

Referred by _____

Age _____ Height _____ Weight _____ Body Fat % _____ Blood Type ____

What information do you hope to learn from an integrative & functional dietitian?

Please list current or previous diseases, medical conditions, or physical ailments.

Please list any medications and/or supplements and/or herbs you are taking.
Please bring supplements and herbs with you to the initial session.

Please describe your current activity/exercise schedule.

Please list any known food allergies or sensitivities to foods you avoid and the reason.

Please describe your weight history (approximate weight each decade beginning with childhood, self-perception, and, if applicable diet type and results).

How do you handle stress?

Describe your sleeping habits. What time do you go to bed and rise?

Would you like to be added to the Nutrition Lifestyle Education Newsletter?

_____ Yes _____ No

Nutrition & Lifestyle Coaching

Office Location:
Scottsdale Office
8124 East Cactus Road
Suite 410
Scottsdale, AZ 85260

Cancellation Policy: In order to best serve clients, Chrissy Barth requires a 48-hour notification for cancelled appointments. By giving advanced notice, we are able to offer other clients who are waiting for services during your appointment slot. Clients who do not cancel appointments within 24 hours will be charged in full for the missed appointment. *Please make sure to email Chrissy this form as well as your health history form at least 48 hours prior to your scheduled appointment time in order to avoid your appointment from being re-scheduled.*

Payment Information: Check, cash, and credit cards are accepted. *Credit cards are subject to a 3% processing fee.*

Patient / Client Agreement (please read and sign below):
*I agree that all the information presented is truthful to the best of my knowledge.
*I agree to a 48-hour cancellation policy (by voicemail to 480.332.8127) otherwise I will be billed for the visit [please provide a credit card # that will be kept on file].

Name on Credit Card _____

Credit Card # _____

CCV _____ Expiration Date _____

Billing Address for CC w/ zip code _____

Patient/Client Signature _____ Date _____

Thank you! In exchange for your efforts, I agree to make my best effort to help you achieve your personal health and lifestyle goals. I look forward to meeting and working with you.