The Seattle Arthritis Clinic

Hello!

Enclosed is a packet of information for you to fill out and bring with you to your appointment. But first, a few important details before we meet:

Information for the day of your appointment

1. Items to bring with you:
   - The attached forms (completed and signed)
   - Picture ID
   - Insurance card
   - Prior medical information including relevant lab results or additional paperwork that you feel would be helpful for me to know

2. The Seattle Arthritis Clinic is located in Suite 250 of the Northwest Outpatient Medical Center building, 10330 Meridian Avenue North, Seattle WA 98133. There is paid parking in the parking lot or plenty of free street parking in the adjacent area.

Insurance and Payment Information

1. If you're using insurance, know your benefits!! Please contact your insurance carrier *prior* to your first appointment to ensure you are covered for your visit. This will prevent any surprises down the road. If you are a private pay patient, please call the clinic for current pricing.

2. When contacting your insurance company be sure to ask the following:
   - "Does my plan cover visits with Nutritionists or Dietitians?" Provide them with the CPT Code: 97802
   - Many plans will only cover for certain diagnoses. Ask about any restrictions applied to your coverage.
   - "Do I need a referral from a doctor in order to see a Dietitian?" If so, contact your family doctor or referring provider.
   - "Is there a limit to the number of visits I can attend over the calendar year or in a lifetime? When does my plan's calendar year end/begin?"
   - Keep record of the time, date and name of the rep providing information.

3. If you have Medicare as your primary provider, note that I am not a Medicare provider and my service is not covered under the plan.

4. If you are unclear about your benefits or are a cash-pay patient, we would highly recommend you pay the cash rate on the date of service to save 30% off the full rate. If your insurance covers, you will be refunded the amount paid. If it does not cover the service, you will not be able to receive the 30% discount at a later time.

Many thanks, and I very much look forward to meeting you!

Heidi Turner, MS, RD, CD

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Personal Information

Name: _____ Age: _____ Birth date: _____ Sex: ____

Address: _____ City: _____ State: ____ Zip: ____

Home Phone: _____ Work : _____ Cell : _____

Email: _____ Occupation: _____

Physician contact: _____ Height: _____ Weight: _____

Where did you hear about the service? _____

Please list your health concerns in order of importance:

1._____ 2. _____ 3. _____ 4. _____

Medications and Supplements

Current Medications (or attach list)

_____

_____

Current Supplements and dosages:

_____

_____

Physical Activity

Do you exercise? If not, please explain contributing factors:

_____

If so, what type of exercise?

_____

How often and for what duration do you exercise?

_____

Food Intolerances or Allergies

Do you have any known food allergies? If so, please list and explain effect: _____

_____

_____

_____

Are there any foods you avoid and/or dislike? _____

_____

Are there any foods you crave? _____

_____

Gastrointestinal Health

Please circle the following if you experience *regularly*. Include frequency and severity:

Gas _____

Bloating _____

Constipation _____

Diarrhea _____

Heartburn _____

Nausea or vomiting _____

_____

Weight History

Are you currently taking or have you taken part in a weight loss program or diet? If so, explain:

_____

_____

Is your weight stable or does it fluctuate? _____

Have you recently gained or loss a significant amount of weight (10# or more)? _____

Do you have a history of emotional eating (eating in response to emotion)? _____

Do you have a history of an eating disorder? _____

_____

_____

_____

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Please note if you experience the following symptoms on a regular basis:

	Often	Sometimes	Rarely
Sinusitis, runny nose or post nasal drip	_____	_____	____
Hives or itchy skin	_____	_____	____
Asthma	_____	_____	____
Anxiety or increased heart rate	_____	_____	____
Difficulty staying asleep	_____	_____	____
Symptoms worsen with stress	_____	_____	____
Symptoms worsen with menstruation	_____	_____	____
Symptoms lessen when on vacation	_____	_____	____

Family Health History (Check S for self, F for father, M for mother, Si for sibling, G for grandparent)

___ Alcoholism	___ Anemia	___ Arthritis	___ Asthma
___ Bowel disease	___ Cancer	___ Celiac Sprue	___ Crohn's
___ Depression	___ Diabetes	___ Eating Disorders	___ Food Allergies
___ Heart Disease	___ High Blood Pressure		___ Hypoglycemia
___ Liver Disease	___ Skin rashes	___ Sinus issues	___ Thyroid

Please list any other significant health issues you feel I should be aware of:

_____
_____
_____

_____

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Social and Nutritional Habits

On a scale of 1-10, rate your average level of stress (1=relaxed/10=stressed) _____

Have you noticed your pain or physical symptoms increase the more stressed you are?
_____

On a scale of 1-10, rate your average level of energy (1=low/10=high) _____

History of smoking? For how long, number of packs per day, and if you've quit, when?
_____

Do you live alone or with others? _____

At which stores do you shop for food? _____

Who does the shopping/cooking? _____

Do you like to cook? _____

Do you have any limitations with cooking that I should be aware of?
_____

Do you have a food budget? Flexible or fixed? _____

_____

How many times per week and where do you typically eat at restaurants (include take-out)?

	Frequency	Location(s)
Breakfast	_____	_____
Lunch	_____	_____
Dinner	_____	_____

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Diet History

Please provide a 3-day food history, including 2 weekdays and 1 weekend day. If you're experiencing pain or gastrointestinal issues, include any symptoms that you experience as well, and note the times. Be specific and try not to change what you eat through the process. Include beverages and any snacks. *Note: if time does not allow you to fill in the form prior to the appointment, we will cover off-form in session.*

Day 1:

Time	Food Eaten	Symptoms

How much water did you drink today?

What other fluids and amounts did you drink today?

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Day 2:

Time	Food Eaten	Symptoms

How much water did you drink today?

What other fluids and amounts did you drink today?

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Day 3

Time	Food Eaten	Symptoms

How much water did you drink today?

What other fluids and amounts did you drink today?