Geri Brewster RD, MPH, CDN

118 North Bedford Rd Suite 100, Mount Kisco, NY 10549
Phone (914) 864-1976 • Fax (914) 864-1967 • scheduling@geribrewster.com

Patient Registration Form

Date:

Name: **Date of Birth:**

How do you prefer to be called (nickname)?

Parent/Guardian's name, if applicable:

Street Address:

City & Zip code:

Cell Phone: **Home Phone:** **Work Phone:**

Email Address:

Please circle your preferred method of contact for appointment reminders.

Please note that we will make every effort to remind you of your appointment, but this is a courtesy and it is your responsibility to be here at your scheduled time.

Primary Physician:

Permission to contact health care providers: Yes / No **Signature:**

How did you hear about Geri?

Reason(s) for visit?

_____

_____

Medical Diagnoses:

Please list any medical diagnosis and conditions that appear in your medical records for which you have been treated. These will be necessary for us to know should you request a super bill for insurance submission purposes. While not all insurance companies provide medical-nutritional therapy for all nutritionally related conditions, some do, and super bills are also requested for flex or health savings plans.

_____

_____

_____

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Please read and initial that you have read and understand the following statements:

The nature of the role of the Medical-Nutritional Consultation is to provide a service that will complement your routine medical care. You are advised to continue to be followed by your primary care physician and other medical specialists.

Acknowledgement – Initial_____

Geri Brewster, in her role as consultant does NOT participate with any insurance plans at this office. *Payment is due at the time the service is rendered.* A receipt is available that you may submit to your insurance company but recognize that your insurance company may not provide medical-nutritional benefits. Accepted payment methods include cash, check, Visa, Mastercard, Discover, and most flex- spending cards. A $40 fee will be assessed if a check payment is rejected because of insufficient funds.

Acknowledgement – Initial_____

Cancellation notification of a scheduled appointment must be received AT LEAST 48 hours prior to the appointment otherwise you will be charged for the visit.

We will be happy to reschedule you with 48 hours notice, otherwise you will be charged for the appointment. This policy is needed given the demand for services and in an effort to accommodate everyone. For any appointment cancelled and not rescheduled, a $50 processing fee is charged.

Acknowledgement – Initial_____

All correspondence shall be handled confidentially. Inquiries will be handled through e-mail or other electronic means as little as possible; we cannot guarantee the security of communications with third party providers despite our best efforts to choose vendors utilizing encrypted storage or transmission via SSL. While we are available to answer brief questions between visits, please note that you may schedule a phone or in-person consultation with a minimum billing increment of 15 minutes for concerns requiring more than a few minutes, and we may bill such increments (or their accumulations, or collaborations and contact with practitioners on your behalf) to your account in our reasonable discretion at our hourly consultation rates. Please inquire for current rates and note that correspondence outside of scheduled visits may not be reimbursable; please check with your insurance provider for details.

Acknowledgement - Initial_____

Purchase of Nutritional Supplements from Geri Brewster, RD MPH CDN

You are under no obligation to purchase nutritional supplements at our office. Supplement recommendations are often made as part of your nutritional plan to optimize outcomes.

As a service to you, we make nutritional supplements available in our office. We purchase these products only from manufacturers who have gained our confidence through considerable research and experience. We determine quality by considering: (1) the quality of science behind the product; (2) the quality of the ingredients themselves; (3) the quality of the manufacturing process; and (4) the synergism among product components. The brands of supplements that we carry in our facility are those that meet our high standards and tend to produce predictable results.

While these supplements may come at a higher financial cost than those found on the shelves of pharmacies or health food stores, the value must also include assurance of their purity, quality, bioavailability (ability to be properly absorbed and utilized by the body), and effectiveness. The chief reason we make these products available is for your convenience as well as to ensure quality. As always, you may bring in your own nutritional supplements for review and comparison.

Returns You may return a supplement with at least six months remaining prior to its printed expiration date for a 5% restocking fee. We do not accept returns of opened, refrigerated or expired supplements.

If you have any questions, please discuss them with Geri.

I, _____, have read and understand the above statement on _____ (date), witnessed by _____, _____(date)

These statements have not been evaluated by the Food and Drug Administration. Nutritional supplements are not intended to diagnose, treat, cure or prevent any disease.

HEALTH HISTORY

Name _____ Date _____

Occupation _____ Age _____ Height _____ Sex _____ Number of Children _____

Marital Status: ❑ Single ❑ Partner ❑ Married ❑ Separated ❑ Divorced ❑ Widow(er)

Are you recovering from a cold or flu? _____ Are you pregnant? _____

Reason for office visit: Date began:

_____ _____

_____ _____

_____ _____

List current health problems for which you are being treated: _____

_____

_____

_____

What types of therapies have you tried for these problem(s) or to improve your health over-all:

❑ diet modification ❑ fasting ❑ vitamins/minerals ❑ herbs ❑ homeopathy ❑ chiropractic ❑ acupuncture ❑ conventional drugs

❑ other _____

Do you experience any of these general symptoms EVERY DAY?

❑ Debilitating fatigue	❑ Shortness of breath	❑ Insomnia	❑ Constipation	❑ Chronic pain/inflammation
❑ Depression	❑ Panic attacks	❑ Nausea	❑ Fecal incontinence	❑ Bleeding
❑ Disinterest in sex	❑ Headaches	❑ Vomiting	❑ Urinary incontinence	❑ Discharge
❑ Disinterest in eating	❑ Dizziness	❑ Diarrhea	❑ Low grade fever	❑ Itching/rash

Current medications (prescription or over-the-counter): _____

_____

_____

Laboratory procedures performed (e.g., stool analysis, blood and urine chemistries, hair analysis):

_____

Outcome _____

_____

_____

Major Hospitalizations, Surgeries, Injuries: Please list all procedures, complications (if any) and dates:

Year	Surgery, Illness, Injury	Outcome
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Circle the level of stress you are experiencing on a scale of 1 to 10 (1 being the lowest): 1 2 3 4 5 6 7 8 9 10

Identify the major causes of stress (e.g., changes in job, work, residence or finances, legal problems): _____

Do you consider yourself: ❑ underweight ❑ overweight ❑ just right Your weight today _____

Have you had an unintentional weight loss or gain of 10 pounds or more in the last three months? _____

Is your job associated with potentially harmful chemicals (e.g., pesticides, radioactivity, solvents) or health and/or life threatening activities (e.g., fireman, etc.)?

_____

What are your current health goals: _____

_____

_____

_____

_____

Medical History

❑ Arthritis
❑ Allergies/hay fever
❑ Asthma
❑ Alcoholism
❑ Alzheimer's disease
❑ Autoimmune disease
❑ Blood pressure problems
❑ Bronchitis
❑ Cancer
❑ Chronic fatigue syndrome
❑ Carpal tunnel syndrome
❑ Cholesterol, elevated
❑ Circulatory problems
❑ Colitis
❑ Dental problems
❑ Depression
❑ Diabetes
❑ Diverticular disease
❑ Drug addiction
❑ Eating disorder
❑ Epilepsy
❑ Emphysema
❑ Eyes, ears, nose, throat problems
❑ Environmental sensitivities
❑ Fibromyalgia
❑ Food intolerance
❑ Gastroesophageal reflux disease
❑ Genetic disorder
❑ Glaucoma
❑ Gout
❑ Heart disease
❑ Infection, chronic
❑ Inflammatory bowel disease
❑ Irritable bowel syndrome
❑ Kidney or bladder disease
❑ Learning disabilities
❑ Liver or gallbladder disease (stones)
❑ Mental illness
❑ Mental retardation
❑ Migraine headaches
❑ Neurological problems (Parkinson's, paralysis)
❑ Sinus problems
❑ Stroke
❑ Thyroid trouble
❑ Obesity
❑ Osteoporosis
❑ Pneumonia
❑ Sexually transmitted disease
❑ Seasonal affective disorder
❑ Skin problems
❑ Tuberculosis
❑ Ulcer
❑ Urinary tract infection
❑ Varicose veins
Other _____
_____

Medical (Men)

❑ Benign prostatic hyperplasia
❑ Prostate cancer
❑ Decreased sex drive
❑ Infertility
❑ Sexually transmitted disease
Other _____
_____

Medical (Women)

❑ Menstrual irregularities
❑ Endometriosis
❑ Infertility
❑ Fibrocystic breasts
❑ Fibroids/ovarian cysts
❑ Premenstrual syndrome (PMS)
❑ Breast cancer
❑ Pelvic inflammatory disease
❑ Vaginal infections
❑ Decreased sex drive
❑ Sexually transmitted disease
Other _____
Date of last GYN exam _____
Mammogram ❑ + ❑ –
PAP ❑ + ❑ –
Form of birth control _____
# of children _____
# of pregnancies _____
❑ C-section _____
Age of first period _____
Date - last menstrual cycle _____
Length of cycle _____ days
Interval of time between cycles _____days
Any recent changes in normal menstrual flow (e.g., heavier, large clots, scanty) _____
❑ Surgical menopause
❑ Menopause

Family Health History (Parents and Siblings)

❑ Arthritis
❑ Asthma
❑ Alcoholism
❑ Alzheimer's disease
❑ Cancer
❑ Depression
❑ Diabetes
❑ Drug addiction
❑ Eating disorder
❑ Genetic disorder
❑ Glaucoma
❑ Heart disease
❑ Infertility
❑ Learning disabilities
❑ Mental illness
❑ Mental retardation
❑ Migraine headaches
❑ Neurological disorders (Parkinson's, paralysis)
❑ Obesity
❑ Osteoporosis
❑ Stroke
❑ Suicide
Other _____

Health Habits

❑ Tobacco:
Cigarettes: #/day _____
Cigars: #/day _____
❑ Alcohol:
Wine: #glasses/d or wk _____
Liquor: #ounces/d or wk _____
Beer: #glasses/d or wk _____
❑ Caffeine:
Coffee: #6 oz cups/d _____
Tea: #6 oz cups/d _____
Soda w/caffeine: #cans/d _____
Other sources _____
❑ Water: #glasses/d_____

Exercise

❑ 5-7 days per week
❑ 3-4 days per week
❑ 1-2 days per week
❑ 45 minutes or more duration per workout
❑ 30-45 minutes duration per workout
❑ Less than 30 minutes
❑ Walk - #days/wk _____
❑ Run, jog, other aerobic - #days/wk _____
❑ Weight lift - #days/wk_____
❑ Stretch - #days/wk_____
❑ Other _____

Nutrition & Diet

❑ Mixed food diet (animal and vegetable sources)
❑ Vegetarian
❑ Vegan
❑ Salt restriction
❑ Fat restriction
❑ Starch/carbohydrate restriction
❑ The Zone Diet
❑ Total calorie restriction
Specific food restrictions:
❑ dairy ❑ wheat ❑ eggs
❑ soy ❑ corn ❑ all gluten
Other _____

Food Frequency

Number of servings per day:
Fruits (citrus, melons, etc.) _____
Dark green or deep yellow/orange vegetables _____
Grains (unprocessed) _____
Beans, peas, legumes _____
Dairy, eggs _____
Meat, poultry, fish _____

Eating Habits

❑ Skip meals - which ones _____
_____
❑ One meal/day
❑ Two meals/day
❑ Three meals/day
❑ Graze (small frequent meals)
❑ Generally eat on the run
❑ Eat constantly whether hungry or not

Current Supplements

❑ Multivitamin/mineral
❑ Vitamin C
❑ Vitamin E
❑ EPA/DHA
❑ Evening Primrose/GLA
❑ Calcium, source _____
❑ Magnesium
❑ Zinc
❑ Minerals, describe _____
❑ Friendly flora (acidophilus)
❑ Digestive enzymes
❑ Amino acids
❑ CoQ10
❑ Antioxidants (e.g., lutein, resveratrol, etc.)
❑ Herbs
❑ Homeopathy
❑ Protein shakes
❑ Superfoods (e.g., bee pollen, phytonutrient blends)
❑ Liquid meals (Ensure)
Others _____
_____

I Would Like To:

ENERGY - VITALITY

❑ Feel more vital
❑ Have more energy
❑ Have more endurance
❑ Be less tired after lunch
❑ Sleep better
❑ Be free of pain
❑ Get less colds and flu
❑ Get rid of allergies
❑ Not be dependent on over-the-counter medications like aspirin, ibuprofen, anti-histamines, sleeping aids, etc.
❑ Stop using laxatives and stool softeners
❑ Improve sex drive

BODY COMPOSITION

❑ Loose weight
❑ Burn more body fat
❑ Be stronger
❑ Have better muscle tone
❑ Be more flexible

STRESS, MENTAL, EMOTIONAL

❑ Learn how to reduce stress
❑ Think more clearly and be more-focused
❑ Improve memory
❑ Be less depressed
❑ Be less moody
❑ Be less indecisive
❑ Feel more motivated

LIFE ENRICHMENT

❑ Reduce my risk of degenerative disease
❑ Slow down accelerated aging
❑ Maintain a healthier life longer
❑ Change from a "treating-illness" orientation to creating a wellness lifestyle

7/00, Rev 1/03, Rev 3/06
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FirstLineTherapy Health Profile

NAME _____ DATE _____ WEEK _____

Rate each of the following symptoms based upon your typical health profile for: □ *Past 30 days* □ *Past 48 hours*

Point Scale	0	*Never* or *almost never* have the symptom	3	*Frequently* have it, effect is *not severe*
	1	*Occasionally* have it, effect is *not severe*	4	*Frequently* have it, effect is *severe*
	2	*Ocasionally* have it, effect is *severe*		

HEAD
_____ Headaches
_____ Faintness
_____ Dizziness
_____ Insomnia
_____ TOTAL

EYES
_____ Watery or itchy eyes
_____ Swollen, reddened or sticky eyelids
_____ Bags or dark circles under eyes
_____ Blurred or tunnel vision (does not include near- or far-sightedness)
_____ TOTAL

EARS
_____ Itchy ears
_____ Earaches, ear infections
_____ Drainage from ear
_____ Ringing in ears, hearing loss
_____ TOTAL

NOSE
_____ Stuffy nose
_____ Sinus problems
_____ Hay fever
_____ Sneezing attacks
_____ Excessive mucus formation
_____ TOTAL

MOUTH/ THROAT
_____ Chronic coughing
_____ Gagging, frequent need to clear throat
_____ Sore throat, hoarseness, loss of voice
_____ Swollen or discolored tongue, gums or lips
_____ Canker sores
_____ TOTAL

SKIN
_____ Acne
_____ Hives, rashes, dry skin
_____ Hair loss
_____ Flushing, hot flashes
_____ Excessive sweating
_____ TOTAL

HEART
_____ Irregular or skipped heartbeat
_____ Rapid or pounding heartbeat
_____ Chest pain
_____ TOTAL

LUNGS
_____ Chest congestion
_____ Asthma, bronchitis
_____ Shortness of breath
_____ Difficulty breathing
_____ TOTAL

DIGESTIVE TRACT
_____ Nausea, vomiting
_____ Diarrhea
_____ Constipation
_____ Bloated feeling
_____ Belching, passing gas
_____ Heartburn
_____ Intestinal/stomach pain
_____ TOTAL

JOINTS / MUSCLE
_____ Pain or aches in joints
_____ Arthritis
_____ Stiffness or limitation of movement
_____ Pain or aches in muscles
_____ Feeling of weakness or tiredness
_____ TOTAL

WEIGHT
_____ Binge eating/drinking
_____ Craving certain foods
_____ Excessive weight
_____ Compulsive eating
_____ Water retention
_____ Underweight
_____ TOTAL

ENERGY / ACTIVITY
_____ Fatigue, sluggishness
_____ Apathy, lethargy
_____ Hyperactivity
_____ Restlessness
_____ TOTAL

MIND
_____ Poor memory
_____ Confusion, poor comprehension
_____ Poor concentration
_____ Poor physical coordination
_____ Difficulty in making decisions
_____ Stuttering or stammering
_____ Slurred speech
_____ Learning disabilities
_____ TOTAL

EMOTIONS
_____ Mood swings
_____ Anxiety, fear, nervousness
_____ Anger, irritability, aggressiveness
_____ Depression
_____ TOTAL

OTHER
_____ Frequent illness
_____ Frequent or urgent urination
_____ Genital itch or discharge
_____ TOTAL

GRAND TOTAL _____

FirstLineTherapy®

Diet Diary / Exercise Log

Name:_____

Please complete your "Diet Diary / Exercise Log" every day.

1.) Make note of the time you wake up.

2.) List and describe in detail all foods and drinks including the amount of each. Make note as to whether the food was fresh, frozen, canned, raw, cooked, baked, fried, etc. Note the time of each meal or snack. Be sure to list everything you eat or drink, including any condiments used (i.e. mayonaise, mustard, relish, etc.).

3.) Keep track of how much water you drink and list the amount in ounces in the section provided. Also note the type and amount of any other drinks you consume.

4.) Write down any activity or exercise you do in the section at the bottom, listing the kind of exercise you did and for how long you did it.

5.) Note any periods of relaxation and what kind of relaxation it was.

6.) Note the time you go to sleep.

Day 1	Date:
Wake up:	
Morning Meal Time:	
Snack Time:	
Mid-Day Meal Time:	
Snack Time:	
Evening Meal Time:	
Snack Time:	
Water (ounces)	
Other Drinks (that are not listed with meals or snacks above)	
Activity/Exercise What kind: How long:	
Relaxation type: How long:	
sleep time:	

FirstLineTherapy®

Diet Diary / Exercise Log

	Day 2 - Date:	Day 3 - Date:
Wake up:		
Morning Meal Time:		
Snack Time:		
Mid-Day Meal Time:		
Snack Time:		
Evening Meal Time:		
Snack Time:		
Water (ounces)		
Other Drinks (that are not listed with meals or snacks above)		
Activity/Exercise What kind: How long:		
Relaxation type: How long:		
sleep time:		

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AUTHORIZATION TO CHARGE CREDIT CARD

I, _____, authorize Geri Brewster RD, MPH, CDN, PC to charge my credit card for any and all balances including those relating to medical-nutritional therapy, purchase of supplements, telephone consultations and e-mails. I agree that if my credit card does not accept the charge, I will immediately make payment to Geri Brewster RD, MPH, CDN, PC for the amount due.

I understand I may cancel this authorization in writing at any time, but by doing so I acknowledge that payment will be expected at the time of service.

_____

PRINT NAME as it appears on the card

_____

Signature and Date

Credit card account number: _____

Billing address: _____ Expiration Date: _____

_____ 3 or 4 Digit Code _____

Practice policy effective November 1, 2014: We require a credit card number on file for all patients in order to schedule appointments. To be considered an active patient receiving ongoing care, we require that the patient be seen in our office at least once per calendar year. All other follow-up appointments may be in person or by telephone/Skype consultation. Payment for all consultations is due at the time of the visit. Geri Brewster RD, MPH, CDN, PC does not participate with any health insurance plans. Please contact your insurance company before committing to our work together to see if medical nutritional therapy is covered under your insurance policy and for which diagnoses it provides coverage.

I acknowledge receiving a copy of this agreement: _____

(Signature and Date)