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

Nutrition Care for Children

Date of Appt:

Your Name:

Child's Name:

Street Address:

City, State & Zip Code:

Best Way to Reach You?

Cell Phone: **Home Phone:**

Work Phone: **Email Address:**

Child's Primary Physician & Contact Info:

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

How did you hear about Geri?

Child's Date of Birth: **Weight at Birth** **Length:**

Preemie at Birth: Yes / No **Type of Delivery:**

Please Indicate: Breast Fed, to age: Formula Fed, from age:
Type of Formula Used:

Child's Allergies:

Medical Diagnoses: Please list any medical diagnosis and conditions that appear in your child's 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.

Current Weight: **Current Height or Length:**

Mom's Age at Delivery: **Specific Health Issues:**

Dad's Age at Delivery: **Specific Health Issues:**

Siblings (Name, Age, Health Issues):

Please describe anything of significance:

1. **Years of Life:**

1-2 Years of Life:

2-3 Years of Life:

3-5 Years of Life (Preschool):

5-10 yrs of Life (Elementary):

Significant Respiratory Infections:

Adverse Reactions to Vaccines:

Adverse Reactions to Foods/Formulas:

Other infections requiring treatment (urinary tract, intestinal, eye, thrush, viral, cuts/wounds, etc.)?

Has your child ever needed antibiotics, antifungal medications (Nystatin, Gentian violet, Diflucan) or other antiviral medications?

Has your child ever needed sutures, stitches, casts, or crutches?

Any surgeries, head injuries, or hospitalizations?

Any medical testing results to share?

What medicines does your child use now (over-the-counter or prescription), if any? Please note name/type, dosage, dates of usage, and who advised/prescribed the meds.

Has your child used medications for mood, attention, or behavior in the past?

What supplements or vitamins does your child take, if any? Please note name/type, dosage, dates of usage, and who advised/prescribed the meds.

What are your child's favorite foods? And least liked foods? (You may be asked to write down what your child eats for 2-3 days).

Diet restrictions, tube feedings, feeding problems (drooling, choking, gagging, reflux, assistance needed, pickiness), or other special diet measures:

Besides food allergies already noted on page 2, are there any other <u>food sensitivities</u> you suspect for your child? What reaction do you see?

Sleep pattern as newborn to 6 months:

Sleep pattern from 6-12 months:

Sleep pattern from 1-2 years:

Sleep pattern currently:

Sensory Disturbances:

Hearing
Vision
Taste
Proprioceptive
Vestibular
Olfactory
Praxis
Tactile

Is there a developmental, learning, or behavioral diagnosis? Yes / No

Age at diagnosis: **Diagnosis given:**

Developmental concerns you have for your child:

Has your child needed assessment or treatment for seizures? Yes / No

What therapies has your child used?

ABA
OT
OT with Sensory Integration
PT
Speech/Language
Berard AIT
Supplements
Medications
Social skills groups / RDI
Homeopathy
Special diets
Tomatis/Listening therapies

List any others you'd like to below:

What are your child's favorite activities? And least liked activities?

What would you most like to achieve with your nutrition care for your child? Is there anything else you would like to share?

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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 child's 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.

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)