Marie Caterini Choppin, LCSW-C & Associates
LOTUS POINT WELLNESS, INC.

Nutritional Health Questionnaire

Name:_____ Today's date:_____
Address:_____
City: _____State: _____Zip:_____
Email address: _____Skype contact (if applicable):_____ Home Phone: _____ Work phone:_____ Cell Phone:_____
What numbers are best for detailed messages?_____
What is your preferred method of contact? _____
Would you like to receive news and recipes? _____
□ Male □ Female DOB: _____ Place of Birth: _____
Genetic background: □ African American □ Native American □ Mediterranean □ Asian □ Caucasian □ Northern European □ Other_____

What would you like help with at this time? _____
_____
_____

Please list your health concerns: **How long have you had these conditions?**
1._____
2._____
3._____
4._____
5. _____ _____

Name and contact information for Primary Physician: _____
_____

Other practitioners: (including acupuncturist, chiropractor, massage therapist, etc.)
_____
_____

Medications and Supplements: *Please list all **prescription medications** and **nutritional supplements, herbs** you are currently taking. Use a separate sheet if needed.*

Medications	**Name**	**Dosage**	**Frequency**	**Length of time**	**Purpose**

Marie Caterini Choppin, LCSW-C & Associates
LOTUS POINT WELLNESS, INC.

LOTUS POINT
Wellness

Nutritional Health Questionnaire

Supplements	Name	Dosage	Frequency	Length of time	Purpose

Have you had prolonged use of any medication in the past (prednisone, acid blocking drugs, tylenol, antibiotics, etc)?
_____
_____

List major traumas, major or minor surgeries, and hospitalizations? _____
_____
_____

Physical Activity and Lifestyle
What kind of physical activities do you do? _____
Are you satisfied with your energy level? _____
Are there any problems/limitations that inhibit your physical activity? _____

Activity	Type(s)	Days per week	Duration
Stretching/Yoga			
Strength Training			
Aerobic/Cardio			
Other			

What do you do for relaxation? _____
How many hours of sleep do you get a night/day? _____ Do you sleep well? _____
Relationship Status: _____ # of times Married:_____ Divorced:_____ Widowed:_____
Current Occupation:_____ How many years? _____ Hours per week?_____
Do you like your work? _____
Passions/Interests? _____

On a scale of 1-10, with 1 being low and 10 being high, how stressful is your
Work: _____ Current health status: _____ Social/family situation:_____ Life in general:_____
What do you believe you can do to make a difference in your current health? _____
_____

LotusPointWellness.com
mchoppin@lotuspointwellness.com
301-960-1198

13200 New Hampshire Avenue
Silver Spring, MD 20904

4405 East-West Highway, Suite 508
Bethesda, MD 20814

Marie Caterini Choppin, LCSW-C & Associates
LOTUS POINT WELLNESS, INC.

LOTUS POINT
Wellness

Nutritional Health Questionnaire

Nutrition

Have you ever had a nutritional consult?_____
Please list **food** allergies: _____
Please list **non-food** and **environmental** allergies: _____
Please list any special dietary restrictions/habits you have: _____
_____
What foods do you crave if anything? _____
What are your favorite foods? _____
Where do you grocery shop? _____
Please describe any changes you have made to your diet to improve your health? _____
_____
How would you describe your relationship to food? _____
_____

Height:_____ Weight: _____ Ideal Weight: _____
Highest Adult weight: _____ Year: _____ Lowest Adult Weight: _____ Year: _____

Food Frequency: How often do you eat or do the following? *Insert a number and circle **day** or **week***

Meals per day: _____	**Red Meat: ____ x d / wk**
Snacks per day: _____	**Chicken/Turkey: ____ x d / wk**
Water _____ ounces per day	**Deli Meat: ____ x d / wk**
Prepare meals: _____ x d / wk	**Fish: ____ x d / wk**
Nuts/Seeds: ____ x d / wk	**Shellfish: _____ x d / wk**
Lentils/Beans: ____ x d / wk	**Organ meat: ____ x d / wk**
Yogurt: ____ x d / wk	**Soy products ____ x d / wk**
Fats and oils: ____ x d / wk *What kinds?*_____	**Eggs: _____ x d / wk**
Dairy Milk/Cheese: _____x d / wk	**ALL VEGGIES: _____ x d / wk**
Other Milk: ____ x d / wk	**ALL FRUIT: _____ x d / wk**
Bread: ____ x d / wk	**Coffee: _____ x d / wk, decaf? _____**
Whole Grains: ____ x d / wk	**Herb or other Tea: _____ x d / wk**
Pasta: ____ x d / wk	**Soft Drinks: _____ x d / wk, diet OR regular**
Chips/crackers etc.: ____ x d / wk	**Frozen Dinners: _____ x d / wk**
Candy: _____ x d / wk	**Alcoholic Drinks: _____ x d / wk**
Fast Food: _____ x d / wk	**Eat fast or on the run: _____ x d / wk**

LotusPointWellness.com
mchoppin@lotuspointwellness.com
301-960-1198

13200 New Hampshire Avenue
Silver Spring, MD 20904

4405 East-West Highway, Suite 508
Bethesda, MD 20814

Marie Caterini Choppin, LCSW-C & Associates
LOTUS POINT WELLNESS, INC.

Nutritional Health Questionnaire

Please use either the form below to record a 3 day food diary, or you may use an app, such as www.myfitnesspal.com, to record and print your diary.

NUTRITION: 3-Day Food Diary

1) Please write down all food and drink, including water
2) Record information as soon as possible after the food has been consumed
3) Do not change your eating behavior, the purpose of this food record is to analyze your current eating habits.
4) Describe the food or beverage consumed. e.g., milk - what kind? (soy, almond, whole, 2%, or nonfat, etc.); toast - (whole wheat, white, buttered); chicken - (fried, baked, breaded), etc.
5) Record the amount of each food consumed using standard measurements as much as possible, such as 8 ounces, 1/2 cup, 1 teaspoon, etc.

Day 1	Day 2	Day 3
Breakfast	Breakfast	Breakfast
Snack	Snack	Snack
Lunch	Lunch	Lunch
Snack	Snack	Snack
Dinner	Dinner	Dinner
Snack	Snack	Snack

LotusPointWellness.com
mchoppin@lotuspointwellness.com
301-960-1198

13200 New Hampshire Avenue
Silver Spring, MD 20904

4405 East-West Highway, Suite 508
Bethesda, MD 20814

Marie Caterini Choppin, LCSW-C & Associates
LOTUS POINT WELLNESS, INC.

Nutritional Health Questionnaire

CREDIT CARD OR DEBIT (ACH) AUTHORIZATION

I authorize **Lotus Point Wellness, Inc.** to use the credit card or ACH information below **to charge my credit card or debit my checking/savings account using an on-line system for the following purposes:**

1. **FOR EACH SERVICE AT THE TIME OF SERVICE** provided to me/and or my child or family by the provider of Lotus Point Wellness Inc.
2. **FOR A MISSED SESSION at the rate of my regular session if I cancel less than 48 hours in advance of my appointment.**
3. **IF AND WHEN MY PAYMENT BALANCE BECOMES PAST DUE.** The provider will inform me about this charge.

I acknowledge that I will be receiving an email with a receipt for the payment and the appropriate information needed to submit to my insurance company and/or for tax purposes.

CREDIT CARD OR ACH INFORMATION Type: ☐ Mastercard ☐ Visa ☐ ACH - for checking/savings account

_____ _____ _____

Credit Card number | 3 digit security code | Expiration

_____ _____

Email for receipts | Credit Card holder's name on card

_____

Address of Cardholder (if different than address listed on front)

ACH: Routing number_____Account Number _____

_____ _____

SIGNATURE **DATE**

LotusPointWellness.com
mchoppin@lotuspointwellness.com
301-960-1198

13200 New Hampshire Avenue
Silver Spring, MD 20904

4405 East-West Highway, Suite 508
Bethesda, MD 20814

Marie Caterini Choppin, LCSW-C & Associates
LOTUS POINT WELLNESS, INC.

Nutritional Health Questionnaire

I have been given or have been directed to the website of Lotus Point Wellness, Inc. and have read the materials provided by my treatment provider regarding Lotus Point Wellness, Inc. I/we have read and understand the background, philosophy and approach that have been disclosed in the statements for the practice AND for therapy, nutritional and/or yoga services, if applicable.

I/we also understand and accept the terms as outlined in the material provided regarding confidentiality, office policies and procedures, fees, and client rights and responsibilities, and the HIPAA policy.

I give permission for my provider of Lotus Point Wellness, Inc. to contact me and/or leave brief messages on any of my voice mails or answering machines confirming, changing or canceling an appointment with the EXCEPTION of (please initial) home work cell.

I/we understand the fees as outlined in the material. Lotus Point Wellness, Inc. will provide a statement of services by e-mail or in-person at my/our session. If my/our insurance plan does not cover services provided, I/we are responsible for the payment. Extended appointments and phone consults will be charged at a pro-rated amount based on the fee for service. I/we also understand that we need to cancel appointments 48 hours in advance by phone in order to avoid a charge for the regular session fee, unless there are extenuating circumstances, as outlined in the material provided.

As a parent, I/we understand that I have the right to information concerning my minor child in therapy, nutrition counseling or yoga except where otherwise stated by law. I also understand that Lotus Point Wellness, Inc. believes in providing a minor child with a private environment in which to disclose himself/herself to facilitate services. I/we therefore give permission to my child's therapist to use his/her discretion, in accordance with professional ethics and state and federal laws and rules, in deciding what information revealed by my child is to be shared with me/us.

HIPAA POLICY CONSENT TO USE OR DISCLOSE INFORMATION FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS (TPO)Federal regulations (HIPAA) allow me to use or disclose Protected Health Information (PHI) from your record in order to provide treatment to you, to obtain payment for the services I provide, and for other professional activities (known as "health care operations."). Nevertheless, I ask your consent in order to make this permission explicit. The Notice of Privacy Practices describes these disclosures in more detail. You have the right to review the Notice of Privacy Practices before signing this consent. I reserve the right to revise our Notice of Privacy Practices at any time. If I do so, the revised Notice will be posted in the office. You may ask for a printed copy of my Notice at any time. You may ask me to restrict the use and disclosure of certain information in your record that otherwise would be disclosed for treatment, payment, or health care operations; however, I do not have to agree to these restrictions. If I do agree to a restriction, that agreement is binding. You may revoke this consent at any time by giving written notification. Such revocation will not affect any action taken in reliance on the consent prior to the revocation. This consent is voluntary; you may refuse to sign it. However, I am permitted to refuse to provide health care services if this consent is not granted, or if the consent is later revoked. I hereby consent to the use or disclosure of my Protected Health Information as specified above. I hereby acknowledge that I have received and have been given an opportunity to read a copy of Lotus Point Wellness, Inc. Notice of Privacy Practices. I understand that Lotus Point Wellness, Inc. is an S Corporation and that if I have any questions regarding the Notice or my privacy rights, I can discuss them with Marie Caterini Choppin, MSW, LCSW-C (Owner/Director). Further inquiries can be addressed to the Secretary of Health and Human Services, 200 Independence Avenue, SW, Washington, D.C. or by calling 202-619-0257.

LOTUS POINT
Wellness

Nutritional Health Questionnaire

Please sign below to acknowledge that you have read, understood and agree to the terms previously described.

_____ _____ Date _____

SIGNATURE of Client PRINTED NAME

_____ _____ Date _____

SIGNATURE of Therapist PRINTED NAME

LotusPointWellness.com
mchoppin@lotuspointwellness.com
301-960-1198

13200 New Hampshire Avenue
Silver Spring, MD 20904

4405 East-West Highway, Suite 508
Bethesda, MD 20814