Do Your Duty-Eat Right PLLC
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6402 N. Santa Fe, Unit B OKC, OK 73116
Phone: 405-517-4374

Patient Information

Date of 1st Appointment_____
Name_____ Date of Birth_____ Age_____
Sex_____
Address_____
_____
City_____ State_____ Zip_____
Telephone: (H)_____ (W)_____
(C)_____
Email_____
Place of Employment or School
attending_____
Primary Care Physician _____MD/DO Ph.#_____-_____-_____
Address
_____
_____

If not referred by your primary care physician, whom may we thank for referring you?
Specialist_____ Friend/Relative_____
Therapist_____
Other
(describe)_____

EMERGENCY CONTACT INFORMATION:

(1) NAME: _____

ADDRESS:_____

CITY:_____ STATE:_____ZIP CODE:_____

PHONE: _____RELATION:_____

(2) NAME: _____

ADDRESS:_____

CITY:_____ STATE:_____ZIP CODE:

PHONE: _____RELATION:_____

How did you hear about Do Your Eat Right, PPLC? _____
May I contact them to thank them for the referral? _____
Please briefly describe what you hope to obtain from our consultation? _____
_____

Please list all prescription Medications

Medication	Dosage	Reason

Please list all vitamins and mineral supplements, protein powders, herbs, etc

Supplement	Dosage	Reason

Circle you Answer:

Do you participate in routine exercise? Yes No
If yes, describe_____
Do you have medical restrictions on your exercise? Yes No
If yes, describe_____
Is your appetite usually good? Yes No
How are most foods prepared in your home?
Baked Broiled Sautéed Deep Fried Microwaved Grilled
Other_____
Where are most of your meals eaten? Home Restaurant Other_____
How often do you eat in restaurants? _____ per day _____per week
What type of restaurants? _____
Do you have trouble chewing food? Yes No
Do you have trouble swallowing? Yes No
Do you salt food? Before tasting after tasting not at all
Do you have a sweet tooth? Yes No
Describe_____
I feel rested during the day. Yes No
Describe_____
List foods you dislike_____
Who does the grocery shopping? _____ cooking?

_____

What foods do you eat between meals?_____

How many cups of water do you drink on an average day? _____ cups (one cup= 8oz.)

The purpose of this questionnaire is to learn which foods you like and dislike. Please cross out any foods you would prefer not to eat or would not buy at the grocery store.

Dairy

Skim milk	1% milk	2% milk	Chocolate milk
Soy milk	Plain low-fat yogurt	Fruited low-fat yogurt	Cottage cheese
Swiss cheese	Cheddar cheese	Grated cheese	
Other:			

Protein

Beef	Chicken	Turkey	Fish
Pork	Ham	Bacon	Sausage
Eggs	Tuna fish	Peanut butter	Shrimp
Soy meat	Black beans	Pinto beans	
Other:			

Starch

Bagel	Pancakes	Corn	White or wild rice
English muffin	Waffles	Potatoes	Pasta
White or wheat bread	French toast	Peas	Popcorn
Pita bread	Granola	Sweet potato	Pretzels
Crackers	Squash	Flat bread	French fries
Dinner roll	Taco shells		
Cereal (hot and cold):			
Chips (potato, tortilla, etc):			
Other:			

Fruits

Apple	Blueberries	Peaches	Apple juice
Applesauce	Cantaloupe	Pears	Orange juice
Banana	Watermelon	Strawberries	Grape juice
Orange	Muskmelon	Mango	Mixed berry juice
Mandarin orange	Pineapple	Dried fruit	Cranberry juice
Grapes	Plum	Canned fruit	
Other:			

Vegetables

Asparagus	Cucumber	Mushroom	Iceberg lettuce
Cauliflower	Green beans	Sweet peppers	Romaine lettuce
Broccoli	Brussels sprouts	Mixed vegetables	Leaf lettuce

Celery	Onion	Roasted vegetables	Spinach
Carrots	Tomato	Oriental vegetables	
Other:			

Condiments and dressings

Butter	Creamy salad dressing	Salsa	Guacamole
Margarine	Italian salad dressing	Guacamole	Hummus
Cream cheese	Spaghetti sauce	Sour cream	
Other:			

Favorite restaurants/menu selection

List your top three restaurant/menu selections:

1. _____
2. _____
3. _____

Please list any additional information about your food preferences that you think would help:

_____
_____
_____

Medical Information. Please check all that apply on the next page.

Medical Condition	Self (Present)	Self (Past)	Parents	Grandparents	Siblings
High Cholesterol					
High Triglycerides					
High Blood Pressure					
Congestive Heart Failure					
Heart Disease (Arteriosclerosis, heart attack,CAD, hardening of the arteries)					
Heart By-Pass Surgery					
Stroke					
Cancer Describe:					
Gall Bladder Disease					
Asthma					
Type 1 Diabetes (requires insulin)					
Type II Diabetes (No insuline required)					
Insulin Pills					
Low Blood sugar					
High Thyroid					
Low Thyroid					
PCOS (polystic ovaries)					
Obesity					
Overweight					
Underweight					
Anemia (iron, B-12 deficient)					
Osteoporosis					
Indigestion/GERD/Reflux					
Ulcers					
Chronic Diarrhea					
Chronic Constipation					
Arthritis (Rhematoid)					
Arthritis (Osteoarthritis)					
Irritable Bowel Syndrome					
Crohn's or Ulcerative Colitis					
Food Allergies: List					
Celiac Disease					
Lactose Intolerance					
Frequent use of antibiotics or corticosteroids Describe Reason:					
Depression,ADD,OCD, Autism					
Eating Disorders					
Physical Handicap					
Inability to gain weight					
Sleep apnea					
Other					

Medical & Lifestyle Questionnaire

Alcohol intake: # drinks per day _____ per week_____ per month _____Type of Alcohol_____

Tobacco usage: never smoke currently smoke quit smoking _____ ago Chew tobacco: Yes or No

Drug usage (marijuana etc....) NO _____ YES _____ (Please describe type & how often)

_____
_____

Weight History

Estimated Height: _____ Estimated Current Weight: _____Usual Weight: _____

Highest Adult Weight: _____at age _____Lowest Adult Weight: _____at age _____

Goal Weight: _____ Pounds gained this year: _____ Pounds lost this year: _____

Is anyone in your family overweight? Y N Is so, who? _____

Weight at age 5: _____Weight at age 13: _____ Weight at age 18: _____
Weight at age 21: _____Weight at age 30: _____Weight at age 40: _____
Weight at age 50: _____Weight at age 60: _____Weight at age 65: _____

Please answer the questions below:

Do you currently want to lose weight? Y N
Have you ever taken diet pills? Y N
Have you ever been put on a special diet? Y N
If so, what type and when,_____
_____
Did you stay on this diet? Y N
List problems you had with the diet: _____
_____
Have you ever seen a registered dietitian before? Y N
If so, where and under what circumstances: _____
_____
Does anyone in the household follow a special diet? Y N
If so, what type of diet/foods: _____
How would you describe your eating habits? Good Fair Poor
Has your appetite changed recently? Y N
How many times a day do you eat? _____
How long does it take you to eat? _____
Do you ever go on an eating binge? Y N
Does this still occur? Y N
Have you ever induced vomiting after you eat? Y N

Do you ever feel extremely guilty after eating?	Y	N
Do you find yourself preoccupied with food?	Y	N
Do you avoid certain foods?	Y	N
If so, which foods: _____		
Have you ever taken laxatives or diuretics for weight loss?	Y	N
Do you skip meals?	Y	N
Do you clean your plate even when you are full?	Y	N
Do you eat when preparing meals or storing leftovers?	Y	N
Do you eat standing up?	Y	N
Do you drink coffee or tea?	Y	N
How much? _____		
Does your weight depress you?	Y	N
Do your emotions/feelings affect food choices?	Y	N

Please Check all that apply
Personal Health History

Leg Cramps		Lack of energy	
Swelling of Joints		Slow wound Healing	
Fainting Spells		Brittle Nails	
Diziness		Skin Rash	
Nose Bleeds		Tingeling in the Hands and Feet	
Blurred Vision		Broken Bones	
Spots in the Light		Depression	
Changes in Vision		Inpatient psychotherapy/counseling	
Recurrent sores in mouth		Outpatient psychotherapy/counseling	
Gum Spreness and Bleeding		Poor growth	
Easily Bruise		Dyspigmentation of Skin	
Dark concentration Urine		Changes in taste	
Glossy red tongue		Dry brittle hair	
Dry cracked lips		Hair loss	
Dry scaly skin		Thin Sparse hair	
White spots on fingernails		Dry eyes	
Sudden weight loss/gain		Other_____	
Weight Loss Surgery		Other_____	

Consent To Release Or Receive Confidential Information

I/We understand that records are protected under Federal and State Law and Regulations and cannot be disclosed without my written consent unless otherwise provided for in the laws and regulations.

I/We do hereby authorize:(Name or Organization) _____

To release to: :(Name or Organization) _____

The following information/records regarding:
(Name of Client)_____,DOB ____/____/____ for records covering the time periods of:_____ through _____.

Specific information to be released:

_____

_____

Purpose and/or need for disclosure:

_____

_____

Method of Transmittal of Information: _____ mail, _____ fax, ____ e-mail, _____verbal, _____other (please list)

_____

Information is to be released (check all that apply):
___at the beginning of treatment ___during the course of treatment ___ at the completion of treatment ___as needed

The information authorized for release may include information which may indicate the presence of a communicable or venereal disease which may include, but is not limited to diseases such as Hepatitis, Syphilis, Gonorrhea, and the Human Immunodeficiency Virus, also known as Acquired Immune Deficiency Syndrome (AIDS).
Re: Psychiatric Records-Oklahoma State Law (76 O.D. Supp. 1986, Section 19) provides that psychological or psychiatric records may be provided to a patient if the treating physician or practitioner consents to the release or upon receipt of a court order, issued by a court of competent jurisdiction. Therefore psychological or psychiatric records will not be released to patients, their guardians or agents (including attorneys) except with the consent of the treating physician or practitioner or upon receipt of a court order, issued by a court of competent jurisdiction.
Re: Drug/Alcohol Abuse Records-Confidentiality of drug/alcohol abuse records is protected by Federal Law. Federal regulations (42 CFR Part 2) prohibit making any further disclosure of this information unless further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A GENERAL AUTHORIZATION FOR THE RELEASE OF MEDICAL OR OTHER INFORMATION IS NOT SUFFICIENT FOR THIS PURPOSE. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol/drug abuse patient.

I/We understand that I/We have the right to revoke this authorization, in writing, at any time, by sending such written notification to Do Your Duty – Eat Right, PLLC. I/We understand that a revocation is not effective to the extent that Do Your Duty – Eat Right, PLLC has relied on the use or disclosure of the protected health information.

Do Your Duty – Eat Right, will not condition my treatment, payment, and enrollment in a health plan or eligibility for benefits if applicable on whether I provide authorization for the requested use or disclosure.

I/We understand that I/We may revoke this consent at any time except to the extent that actions have been taken in reliance on it. This consent will expire on: _____

_____	_____	_____	_____
Client	Date	Parent or Guardian	Date
_____	_____	_____	_____
Staff/Witness	Date	Clinician's Review (If release is to client/family member)	Date

Email Consent Form

Client Name: _____Date:_____

Email Address:_____

RISK OF USING ELECTRONIC MAIL

Transmitting client information by email has a number of risks that clients should consider before using email. These include, but are not limited to, the following:

- Email can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.
- Email senders can easily misaddress an email.
- Backup copies of email may exist even after the sender of the recipient has deleted his or her copy.
- Employers and on-line services have the right to inspect email transmitted through their systems.
- Email can be intercepted, altered, forwarded, or used without authorization or detection.
- Email can be used to introduce viruses into computer systems.
- Email can be used as evidence in court.
- Emails may not be secure and therefore it is possible that a third party may breach the confidentiality of such communications.

CONDITIONS FOR THE USE OF ELECTRONIC MAIL

Do Your Duty – Eat Right PLLC cannot guarantee but will use reasonable means to maintain security and confidentiality of email information sent and received. Do Your Duty – Eat Right PLLC and its employees are not liable for improper disclosure of confidential information that is not caused by intentional misconduct. Patients must acknowledge and consent to the following conditions:

- Email is not appropriate for urgent or emergency situations. Provider cannot guarantee that any particular Email will be read and responded to within any particular period of time.
- Email must be concise. The client should schedule an appointment if the issue is too complex or sensitive to discuss via email.
- All email will be printed and filed in the client's medical record.
- Office staff may receive and read your messages.
- The client should not use email for communication regarding sensitive medical information.
- Provider is not liable for breaches of confidentiality caused by the client or any third party.
- It is the client's responsibility to follow up and/or schedule an appointment if warranted.

CLIENT ACKNOWLEDGEMENT AND AGREEMENT

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of email between Do Your Duty – Eat Right PLLC and me, and consent to the conditions and instructions outlined, as well as any other instructions that the Provider may impose to communicate with clients by email.

Print Name:_____ Date:_____
Signature:_____ Date:_____
Witness Signature:_____ Date:_____

New Client Registration

Client Information

Name:	DOB:

Address:		
Marital Status:	Sex	M F

Contact Information – please circle your preferred contact method

Telephone – Day/Evening		Cell Phone/ Text Message or both	
Email Address:			

Primary Care Physician

Name:		Phone Number	
Address:			
Relationship with physician (i.e. what do you see her/him for, when was your last apt., etc.)			

Psychotherapist/counselor/therapist

Name:		Phone Number	
Address:			
Relationship with physician (i.e. what do you see her/him for, when was your last apt., etc.)			

Psychiatrist/Psych-pharmacologist

Name:		Phone Number	
Address:			
Relationship with physician (i.e. what do you see her/him for, when was your last apt., etc.)			

☐ I give my clinician at Do Your Duty – Eat Right, PLLC permission to speak with and disclose my protected health information with the above named treatment providers.

Signature: _____ Date: _____

Special Treatment Team Recommendations

Do Your Duty – Eat Right, PLLC employs an integrative model for the treatment of eating disorders. The American Psychiatric Association's best practice recommendations include a

treatment team of a primary therapist, primary care provider, dietitian and family involvement. You may use your own providers or accept our recommendations. Family involvement is crucial for client support and may include a recommendation for family therapy. Eating disorders pose a medical risk and therefore require close monitoring. Client's who have a BMI of 18.5 or less will be asked to include a primary therapist, primary care provider, dietitian and family involvement on their treatment team allowing communication to occur between them. Clients who are actively using dangerous compensatory behaviors such as purging or laxative use or have a serious medical condition will be asked to include a primary care provider and family involvement on their team. At times, compromised clients may be asked to provide lab results or weigh in for the therapist. There are situations where outpatient treatment becomes ineffective or is inadequate and a higher level or care will be recommended. Do Your Duty – Eat Right, PLLC will provide you with resources. My goal is to keep you safe and restore you to health in an effective and efficient manner.

The following is recommended for your treatment. Initial responses. Date(s)	Accept	Not Accept
_____ Primary Therapist _____	_____	_____
_____ Primary Care Provider _____	_____	_____
_____ Nutritionist (RD) _____	_____	_____
_____Family Involvement _____	_____	_____
_____Other _____	_____	_____
_____ Group Therapy _____	_____	_____
_____ Intensive Outpatient _____	_____	_____
_____ Inpatient/Residential _____	_____	_____

Our client's have the right to accept or not accept our treatment recommendations. Some recommendations are necessary for your health and safety, non-compliance with those recommendations could result in withdrawal of services or at minimum, require behavioral contracting. By signing below, you are acknowledging that you have been informed of the above recommendations and understand the risks of non-compliance with recommendations.

_____ _____ _____ _____

Print Name (client or parent/guardian) Sign Name Date (s)

Do Your Duty – Eat Right, PLLC

Fee Schedule

Client Name: _____ Date:_____

Date	Services Provided	Charges
	Group Consultation	$150.00
	Initial Consultation *60-75 minutes*	$150.00
	Follow-Up Consultation *30-45 minutes*	$100.00
	Weight Check In *10-15 minutes*	$35.00
	Group Therapy *30-45 minutes*	$50.00
	Returned Check Fee	$35.00
	TOTAL DUE	
	PAYMENT	
	BALANCE	

PAYMENT METHOD:

_____ CASH

_____ CHECK _____ CHECK NUMBER (A fee of $35 will be collected for any returned check)

_____ CREDIT CARD _____ VISA _____MASTERCARD _____DISCOVER

Card Number: _____ Expires:_____ CVV:_____

Name on Card: _____

Signature: _____