CHERNUS NUTRITION, PLLC
Andrea Chernus, M.S., R.D., C.D.E., C.S.S.D.
133 W. 72nd St. Suite 703 New York, NY 10023
Phone: 212-579-7070 Fax: 212-579-9581 e-mail: arc@ChernusNutrition.com

Thank you for making an appointment with Chernus Nutrition, PLLC. Andrea Chernus welcomes you as a new patient and looks forward to helping you achieve the results you desire.

- Please read all information, and fill out all forms completely. Please be sure to submit them *prior* to your appointment, so that your scheduled time may most beneficial to you.
- Your appointment is a reservation for a specific time slot. Only one person is seen at a time, and we adhere to our schedule. Please be ON TIME. If you are late, you will be seen, but the duration of your visit will be shortened.
- You will receive a phone call to confirm your appointment one business day before each visit. If there is any question as to the time or location (there is only one office) please call. If you need to cancel, please give as much notice as you can.
- Cancellations made less than 24 hrs in advance are subject to a $50 fee.
- Payment is due at the end of each session. Personal checks, cash, most Health Savings Account cards, and personal credit cards: Visa, MasterCard, Discover and American Express are accepted.
- You will be asked for a credit card to be kept on file, to be used for insufficient cancellation time.
- If you need reading glasses, please bring them with you.
- Please have your physician fax your blood work to 212-579-9581 prior to your visit. This is extremely important for those with Diabetes (including borderline), high cholesterol, eating disorders, kidney disease, thyroid disease, PCOS or anemia.
- Pre-paid sessions must be utilized within 6 months from date of purchase.
- There are no refunds on any services rendered or pre-paid sessions after expiration stated above.

Please fax this page, the following three pages, and the Food and Exercise Journal pages to:

212-579-9581

I have read Chernus Nutrition's office policies and agree to the terms. I understand that I will be responsible for any fees incurred in collecting unpaid balances (bounced checks, attorney, collection agency).

X____Date_______________

Patient Signature

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PATIENT INFORMATION

Name____Date_______________
Home Address____
City______________________________State__________Zip________________
Please supply at least one land – line:
Work Phone________________Home Phone________________Cell Phone__________
Date of birth ________________________E-mail:_____________________________
Social Security Number______________________
Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed
Employer____________________________Referred by______________________
Physician's Name____
Physician's Address____
Physician's Phone____

Age______Height_________Current Weight________

What has been your lowest adult weight? __________ When was this?____________
What has been your highest adult weight?__________When was this?____________
Would you like to: Lose weight _____
Gain weight______
Maintain current weight_____
What would you like to accomplish by seeing a nutritionist? Do you have specific goals?
____
____
____

Please circle all that apply to you:

Anemia	Cancer	Diabetes	Heartburn/acid reflux	Hypoglycemia	Overweight
Anorexia	Celiac	Diverticulitis	Heart attack	Irritable Bowel	PCOS
Arthritis	Crohn's	Eating disorder	Hiatal Hernia	Kidney disease	Pre-diabetes
Binge Eating	Colitis	Food allergies	High Blood Pressure	Lactose intolerance	Sleep apnea
Bipolar	Constipation	Gallbladder disease	High Cholesterol	Osteoporosis	Stroke
Bulimia	Depression	Gout	H.I.V.	Obesity	Thyroid

Other (please explain)
____
____

Family History (mark M for mother; F for father)
Cancer__________Heart Attack____________High Cholesterol_____________
Diabetes_________High Blood Pressure________Overweight_______________
Other significant family history____

Please list any prescription medication you are taking, dosage and the condition involved
____
____
____

List any vitamin, mineral and herbal supplements you are taking and dosage if known
____
____
____

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Do you smoke:
Cigarettes: Yes______No______Quit_______how long ago?_______________
Cigars: Yes_____No_____
Marijuana: Yes____No____
Do you drink alcohol? Yes____How much/often______________________________No_____
If you exercise, describe your regime including how often and for how long you participate:
____
____
____

What time do you go to sleep on week nights? _____________________On week-ends?____________
What time do you wake up on week days? ________________________On week-ends?____________

Have you ever followed any special diet? If so, please describe______________________________________
____

Are you currently following a special diet? If so, please describe_____________________________________
____

List any foods you have an allergy or intolerance to and the symptoms you experience:
____
____
____

List any foods that you intensely dislike or would refuse to eat:
____
____
____

How many times per week do you go out or have take-out food, for:
Breakfast __________Lunch _____________Dinner ____________
How many times per week do you or does someone in your family prepare the following meals:
Breakfast __________Lunch ____________Dinner ___________

Do you crave any foods? If so, please specify____
____
____

Is there anything else that you would like me to know about you? ___________________________________
____
____

By signing this form, I authorize you to exchange medical information with my Primary Care Provider, listed above. I understand that you respect my privacy, and take all necessary steps to protect the privacy of my medical information. I have received and agree to Chernus Nutrition's HIPAA agreement.

X____Date____________
Patient Signature