



3240 Burnt Mill Drive ♦ Suite 1 ♦ Wilmington, NC 28403 ♦ Tel: 910-790-9500 ♦ Fax: 910-796-8111

CONFIDENTIAL CLIENT INFORMATION

Welcome to the Chrysalis Center. Please complete the front and back of each page to help your clinician provide appropriate services. In accordance with our professional codes of ethics and state and federal law, any information you provide is strictly confidential.

Demographic Information:

Name _____ SSN _____ Date _____

Mailing Address: _____

City: _____ State _____ Zip Code _____

Email Address: _____

Home Phone: _____ Work Phone _____ Cell Phone: _____

What is the best way to contact you? _____ Is it okay to leave a message? Yes No

Date of Birth _____ Age _____ Sex _____ Ethnic Group _____ Religious Preference _____

Relationship Status:

Single _____ Cohabiting _____ Married _____ Separated _____ Divorced _____ Widowed _____

Emergency Contact: _____ Telephone: (_____) _____

Parent/Guardian (if relevant): Name: _____

Address: _____ Telephone: (_____) _____

Referral Information:

How did you find out about our services? _____

Employment Information:

Are you currently employed? Yes No

If yes, where are you employed? _____

What is your job title? _____

For Office Use Only: Date of Last Information Update and Initials of Staff Member Completing:

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Education Information:

Highest Level of Education Completed:

Grade School _____ High School _____ College _____ Graduate School _____

Are you currently a student? Yes No

If yes, where? _____ Year _____ Major _____

Nutrition Counseling History:

Have you ever met with a nutritionist before? Yes No

If Yes:

Name of nutritionist(s): _____

Presenting problem: _____

When and why did you stop? _____

Health Information:

Please list any chronic illnesses, injuries, physical conditions or disabilities: _____

Allergies/Adverse Reactions to Treatment: _____

Primary Care Physician Name: _____

Telephone: (_____) _____ Address: _____

Current Medications

Supplements & Vitamins

Daily Dose

Start Date

Name of Prescriber

Supplements & Vitamins	Daily Dose	Start Date	Name of Prescriber

Weight and Exercise History

How tall are you? _____ Current Weight _____ Desired Weight _____

Lowest Weight _____ Date/age of this weight _____

Highest Weight _____ Date/age of this weight _____

How often do you weigh yourself? _____

Briefly describe any diets you have tried and how long you followed them:

Briefly describe your exercise habits (current and past):

Please list any nutrition/eating pattern/exercise goals that you hope to achieve as a result of nutritional counseling. Also please include any other information when you feel would be helpful.

Check below if you or any family member(s) are currently experiencing or have experienced any of the following?

	Self	Family		Self	Family
Anemia	_____	_____	Alcohol Abuse	_____	_____
Hypoglycemia	_____	_____	Drug Abuse	_____	_____
Diabetes	_____	_____	Sexual Abuse	_____	_____
High Blood Pressure	_____	_____	Emotional Abuse	_____	_____
High Cholesterol	_____	_____	Physical Abuse	_____	_____
Heart Disease	_____	_____	Rape	_____	_____
Irritable Bowel	_____	_____	Stealing / Shoplifting	_____	_____
Diverticulitis	_____	_____	Chronic Health Problems	_____	_____
Intestinal Problems	_____	_____	Workaholism	_____	_____
Cancer	_____	_____	Anxiety/ Panic Disorder	_____	_____
Anorexia Nervosa	_____	_____	Depression	_____	_____
Bulimia Nervosa	_____	_____	Mood Swings	_____	_____
Binge Eating	_____	_____	Bipolar Disorder	_____	_____
Obesity	_____	_____	Emotional Problems	_____	_____
Laxative/Diuretic Use	_____	_____	Nervous Breakdown	_____	_____
Compulsive Overeating	_____	_____	Suicide attempt/ideation	_____	_____
Other _____			Psychiatric Hospitalization	_____	_____

Food Allergies: _____

Food Intolerances: _____

Foods Avoided: _____

Is there any other relevant information that we have not asked about?



**Insurance is filed as a courtesy. All unpaid balances will be the responsibility of the client. It is the client's responsibility to notify Chrysalis of any information that has changed.*

INSURANCE INFORMATION

Client Information:

Full Name (Including Middle): _____

Address: _____

Telephone: _____

Birth Date: _____

Social Security Number: _____

Relationship to Policy Holder: _____

Primary Insurance Information (family member whose insurance you are covered by):

Policy Holder's Full Name (Including Middle): _____

Policy Holder's Address: _____

Policy Holder's Telephone: _____

Policy Holder's Birth Date: _____

Policy Holder's Social Security Number: _____

Employer's Name: _____

Insurance Plan Name: _____

Subscriber Number or Member ID Number: _____

Group Number: _____

* Please see reverse side for secondary insurance information and consenting signature.

Secondary Insurance Information (If applicable):

Policy Holder's Full Name (Including Middle): _____

Policy Holder's Address: _____

Policy Holder's Telephone: _____

Policy Holder's Birth Date: _____

Policy Holder's Social Security Number: _____

Employer's Name: _____

Insurance Plan Name: _____

Subscriber Number or Member ID Number: _____

Group Number: _____

I have read and completed the information above and verify that it is correct. I understand that it is my responsibility to update Chrysalis with any change in insurance information.

Name of Client (printed)

Date

Signature