Office Use Only: Medical ID # ________

Medical Nutrition Therapy Service Components
Initial Evaluation and Counseling

* Please note this form has been developed as a comprehensive Medical Nutrition Therapy Assessment. The topics that have been bolded and italicized indicate the minimum requirements for Medicaid billing and reimbursement**.**

Demographics:

Name: ____
Date of Birth: ____________________ ***Age:***____ years _____ months
Gender: ____ M ____F ***Race/Ethnic Background***: __________________________
Current Phone Numbers: ______________ (Home) ______________ (Work) ___________(Cell)
Parent/Guardian Name: ____
Relationship of Guardian to patient:____

I. Medical Management

A. Medical history

- ***Patient's primary physician***: ____
- Date of your child's last well-child visit ____________________________________
- Doctor/location of last well-child visit. ____________________________________
- Do you have any medical appointments scheduled for your child? _____Yes ____ No

If yes, with whom ____
Reason: ____Well-child visit ___ Sick visit ____Follow-up visit ____Other
Scheduled date: ______________________________ Time: ________________

- ***Does your child have any of the following medical conditions?*** ***Medications***

Asthma __Yes __No ______________
Diabetes __Yes __No ______________
Type I __Yes __No ______________
Insulin dose ___________________________
FSBS: Frequency ___________________________
Meter Brand: ______________________________
FSBS average values over past week: ___________
Lowest and Highest Blood Sugar over past week______
Last Hgb A1C value: ____________

Type II __Yes __No ______________
FSBS: Frequency ___________________________
Meter Brand: ______________________________
FSBS average values over past week: ___________
Lowest and Highest Blood Sugar over past week________
Last Hgb A1C value: ____________

High Blood Pressure __Yes __ No ______________
High Cholesterol __Yes __ No ______________
High Triglycerides __Yes __ No ______________
Hyperinsulinemia (Too much insulin production) __Yes __ No ______________
Insulin resistance (Body's cells resistant to the action of insulin) __Yes __ No ______________
Skin Tags

Acanthosis Nigricans (Dark brown discoloration of the neck) __Yes __ No _______________

Sleep Apnea __Yes __ No ______________

If yes, does your child use a CPAP machine? __Yes __ No _______________

Does your child snore? __Yes __ No _______________

Does your child fall asleep during the day or at school? __Yes __ No _______________

Does your child have problems with bedwetting? __Yes __ No ______________

Bone /Joint Problems __Yes __ No _______________

If yes, what type of problem__________________________

Is your child receiving treatment for this problem? __Yes __ No ______________

If so, what kind treatment?___________________________

Depression __Yes __No _______________

ADHD __Yes __No _______________

Other Medical Conditions____

Other medications____

- ***Does your child have allergies*?** __Yes __No

  Food ___ Environment ____ Medication ____ Other _____________________________

  If yes, explain. ____
- Do you currently have any concerns regarding your child's health? __Yes __No

  If yes, please comment: ____
- Has your child been given a prescription by the doctor for a special diet? __Yes __No
  - If so, what is your child's special diet? ____
- Has your child been given a prescription by the doctor for a exercise? __Yes __No
  - If so, what is your child's special exercise prescription? _________________________________
  - Has your doctor cleared your child for physical activity? __Yes __No
  - If no, explain restrictions ____

Getting to Know Your Child

1. Do you know your child's Body Mass Index (BMI)? ____ Yes ___ No

   If yes, what is your child's most recent BMI? __________ BMI Percentile: _____________

   Did your doctor discuss your child's BMI chart with you? ____ Yes ____ No
2. Over the last 6 months, has your child's weight:

   ___Increased (Amount: ______ pounds) ___ Decreased (Amount: _____ pounds)

   ___Stayed the same ___ Unsure
3. Do think your child is overweight/obese or has a problem with his/her weight? ___ Yes ___ No

   What are your feelings about this problem? ____
4. What have you done in the past to help your child control his/her weight?_________________

   ____
5. How long has your child been overweight?

   ___ Since infancy (0-12 months) ___ Since early childhood (1-5 years)

   ___ Since childhood (6-12 years) ___ Since a teenager (13 years or older

B. *Psychosocial history*

- ***Family Information***
  - Mother/Guardian Name: ____

    Mother/Guardian Work Number: ___________Work Location: ______________________
  - Father Name: ____

    Father Work Number: _______________ Work Location: __________________________
  - If we need to reach you, is it OK to leave a message at your home number? __ Yes __ No
  - Is it OK to contact you at your work number? ___ Yes ___ No

Names and ages of brothers and sisters who live in the home:
____
____
____
Names, ages, and relation of others living in the home*
____
____
____
(* Place a star beside the name of any person living in the home that is has a problem with weight.)

Who does the patient spend most of his/her time with? ______________________________
Where does the patient eat most meals and snacks when not in school? __________________
How is the best way to provide health and nutrition education?
___ Verbal ___ Written handouts ___ Pictures ___ Other (Explain: ___________)

- **School Information**

School: ____
Grade: ___________________ Homeroom Teacher: _______________________
School Nurse: ____
Approve for School Nurse to measure height, weight, and BMI at school? ___ Yes ___ No
How are your child's grades? __ Great __ Good __ Fair __ Poor ___ Failing grade
Has your child's school performance changed this school year:
___ Up ___ Down ___ Stayed the same
How many school days has your child missed this year due to health issues related to being overweight/obese? (This may include sick days and days missed due to doctor visits related to medical issues related to weight problems.) ___________days
How does your child travel to school? ___ School bus ___ Walk ____ Parent drive
How does your child travel from school? ___ School bus ___ Walk ____ Parent drive
What time does your child leave for school? _______a.m.
What time does your child arrive home from school? _______p.m.
Does your child receive a special diet at school? ___ Yes ___ No
If yes, what is this diet? ____
Does your child receive free or reduced meals at school? ____ Yes ___ No
___ Breakfast ___ Lunch ___ Carries lunch from home ____ Purchases extra food in cafeteria
___ Skips ___ Other (Explain: ______________________________________)
If no, explain ____

Psychosocial Information

- Some people gain weight because something serious or upsetting has happened in their family or to them. Please check if any of these things has happened in your family and note how old your child was when they happened.

			Comments
Divorce	___Yes (Age: _____)	___No	____________________
Father remarries	___Yes (Age: _____)	___No	____________________
Mother remarries	___Yes (Age: _____)	___No	____________________
Change homes (Move)	___Yes (Age: _____)	___No	____________________
Change schools	___Yes (Age: _____)	___No	____________________
Family member incarcerated	___Yes (Age: _____)	___No	____________________
Death of close family member	___Yes (Age: _____)	___No	____________________
Death of favorite pet	___Yes (Age _____)	___No	____________________
Other: _______________	___Yes (Age:_____)	___No	____________________

- If you answered yes to any of the above questions, please explain: ______________________________

Home Environment

A. ***Assessment of Living Conditions*****:**

___ House ____ Mobile Home ____ Homeless Shelter ____ Other (Explain:_______)
___ Indoor plumbing *(**Source of water**:* ____ Public/City ____ Private well, tested)
___ ***Working Stove*** ___***Working Refrigerator*** ___ ***Microwave***
Heating Source: ___Central (__ Oil ___ Gas ___ Electric) ___Space Heater ___Kerosene
___Woodstove ___Electric
___Portable electric ___None
Cooling: ___Air Conditioner (___ Central System ___Window unit) ___ Fans ___ None

B. Resources for Food**:**

___ Food Stamps ___ WIC ___ Food Bank/ ___ Church Pantry Ministry
___ Farmers' Market ___ Home garden ___ Other (Explain:______________________)
Where majority of grocery shopping is done? (Store name) ______________________________
How often do you go grocery shopping ? ______________________________
Who does most of the grocery shopping? ______________________________
Do you use store/product coupons when grocery shopping? ____ Yes ____ No
Do you feel you have adequate funds for food? ______Yes ______ No

C. Transportation**:**

___ Own Vehicle ___Bus/Public Transportation ___ PATS van
___ Taxi ___ Neighbor ___ Relative
___ Walk ___Bicycle

D. Lifestyle Habits

Some lifestyle habits can contribute to excessive weight gain. Which habits does your child have?

Eat in front of TV, computer, video games _____ Yes _____ No
Eat while talking on phone _____ Yes _____ No
Eat when others are not watching _____ Yes _____ No
Vomits after eating too much _____ Yes _____ No
Takes laxatives after eating too much _____ Yes _____ No
Eats when bored _____ Yes _____ No
Eats more than 1 serving at a meal or snack _____ Yes _____ No
Eats snacks at unplanned times ("grazing") _____ Yes _____ No
Eats when friends put pressure on him/her _____ Yes _____ No
Eats when family members put pressure on him/her _____ Yes _____ No
Has television in bedroom _____ Yes _____ No
Sleeps less than 8 hours per night _____ Yes _____ No
If less than 8 hours, how many hours?_______________
Has greater than 2 hours of screen time daily _____ Yes _____ No
If yes, how many hours daily? ____________________
Eats at least one meal a day as family seated together at a table _____ Yes _____ No
If no, where are meals eaten? ____________________

How do you reward your child for his/her accomplishments? ______________________________

Activity and exercise can have an effect on your child's weight. Please check which habits your child has:

Play sports (basketball, soccer, softball, etc.) _____ Yes _____ No

If yes, how often? ____

Exercises (run, walk fast, swim, dance, etc.) _____ Yes _____ No

If yes, how often? ____

Toning exercise (sit ups, toe touches, leg lifts, etc.) _____ Yes _____ No

If yes, how often? ____

If your child has an afternoon of free time, what would he/she do? ______________________________

Does your child participate in afterschool care?__________. If so where? (afterschool program, daycare, babysitter, family members, etc.)____

Support System**:** Other people can be helpful with weight management.

Who can be most helpful to you and your child when trying to get to a healthy weight? _______________

Who can be least helpful (make it harder)? ____

Outside of your immediate home, which family members or close friends do you have who are overweight or obese? ____

C. Treatment Plan (as they impact nutrition interventions)

III. Diagnostic nutritional assessment

A. Review and interpretation of pertinent laboratory and anthropometric data

Laboratory Data:

Date	*Laboratory Test*	*Value/Results*	*Comment*

Anthropometric Data:

Date	*Height (cm/inches)*	*Height/Age Percentile*	*Weight (kg/pounds)*	*Weight/Age Percentile*	*BMI*	*BMI Percentile*	*Comments*

Waist Circumference: inches_______ cm:_________

Blood Pressure: Systolic___ Diastolic____ Blood Pressure Percentile for age and gender:_______

***Degree of Obesity (based on BMI Grid*)**:**

___ Normal weight

___ Overweight

___ Obese

___ > 99th percentile

Estimated Ideal Body Weight (IBW):

IBW @ 50th percentile: _______ kg

Percent of IBW: ________ %

Adjusted IBW @ 85th percentile: ______ kg

Percent adjusted IBW: _________ %

Stage of intervention/treatment:
___Step 1
___Step 2
___Step 3
___Stage1
___Stage 2
___Stage 3
___Stage 4

B. Analysis of dietary and nutrient intake (include physical activity/screen time)

Usual Food Intake

Week Day

Breakfast Time:	AM Snack Time:	Lunch Time:	PM Snack Time:	Dinner Time:	HS Snack Time:

Weekend Day

Breakfast Time:	AM Snack Time:	Lunch Time:	PM Snack Time:	Dinner Time:	HS Snack Time:

Some eating habits can cause weight gain. Please check which habits your child has:
Eat breakfast _____ Yes _____ No
Eat lunch _____ Yes _____ No
Eat more than 3 snacks per day _____ Yes _____ No
Skips breakfast _____ Yes _____ No
Skips lunch _____ Yes _____ No

Skips dinner _____ Yes _____ No
Drinks 2 or more servings of sweet drinks/day (8 oz) ____ Yes _____ No
Type: ___Sweet Tea ___Soda ___Kool-Aid ___Fruit Drink/Punch
Drinks 2 or more 4 ounce servings of 100% juice/day _____ Yes _____ No
How often eating fast food each week: _____ day(s)
Typical place and meal: ____

Nutrition Diagnosis

American Dietetic Association Nutrition Diagnostic Terminology for Overweight Children
***Note the codes provided below are suggestions. Assess for appropriateness and revise/add as necessary.**

Intake Domain	Clinical Domain	Behavior/Environmental Domain
Energy Balance: Excessive energy intake NI- 1.5	Weight: Overweight/obesity NC -3.3	Knowledge and Beliefs: Food and nutrition related knowledge deficit NB- 1.1
Nutrient: Imbalance of nutrients NI- 5.5	Weight: Involuntary weight gain NC -3.4	Knowledge and Beliefs: undesirable food choices NB- 1.7
Fat and Cholesterol: Excessive fat intake NI -5.6.2		Physical activity: physical activity NB -2.1
Protein: Excessive protein intake NI -5.7.2	Altered nutrition related laboratory values NC- 2.2	Food safety and access: limited access to food NB- 3.2
Carbohydrate: Excessive carbohydrate intake NI- 5.8.2		
Inappropriate intake of types of carbohydrate NI- 5.8.3		
Inconsistent carbohydrate NI- 5.8.4		
Inadequate fiber intake NI -5.8.5		

#1 Problem: ____
Etiology: ____
Signs/Symptoms: ____

#2 Problem: ____
Etiology: ____
Signs/Symptoms: ____

B. Determination of nutrient-drug interactions

C. Assessment of feeding skills and methods – structured feeding

IV. ***Development of an individualized nutrition care plan***

1. ***Recommendations for nutrient and calorie modification***:

Estimated energy needs: __________ calories per day
Estimated protein needs: __________ grams per day (_________% protein)
Estimated carbohydrates needs: __________ grams per day (________% CHO)
Estimated fat needs: __________ grams per day (________% fat)

Nutrition Prescription: ____
____

American Dietetic Association Nutrition Intervention Terminology for Overweight Children
***Note the codes provided below are suggestions. Assess for appropriateness and revise/add as necessary.**

Food and/or Nutrient Delivery	Nutrition Education	Nutrition Counseling	Coordination of Nutrition Care
Meals and snacks: General Healthful Diet ND 1.1	Initial/Brief Nutrition Education: Purpose of the nutrition education E 1.1	Theoretical Basis/Approach: Cognitive-Behavioral Theory C 1.2	Coordination of other care during nutrition care: Team Meeting RC 1.1
Meals and snacks: Modify distribution, type or amount of food and nutrients within meals or at a specified time ND 1.2	Initial/Brief Nutrition Education: Priority Modifications E 1.2	Theoretical Basis/approach Health Belief Model C 1.3	Coordination of other care during nutrition care: Collaboration/referral to other providers RC 1.3
Meals and snacks: Specific foods/beverages ND 1.3	Comprehensive Nutrition Education: Purpose of nutrition education E 2.1	Strategies: Motivational Interviewing: C 2.1	Coordination of Care during nutrition care: Referral to community agencies/programs RC 1.4
Vitamin and Mineral Supplements: Mineral:Calcium ND 3.2.4	Comprehensive Nutrition Education: Recommended Modifications E2.1	Strategies: Self Monitoring C 2.3	
		Strategies: Goal setting C 2.2	

2. *Calculation of a therapeutic diet for certain disease states (i.e. diabetes, renal disease):*

Calculation needed for therapeutic diet? ________

If yes, describe: ____
____
____
____

Suggested Meal Plan:

Grains: ________ ounces/day (total)

- whole grains: ________ ounces/day

Fruit: ________ cups/day

Dairy: ________ cups/day

Vegetables: ________ cups/day

Meat & Beans: ________ ounces/day

Fats/Oils: ________ tsp / tbsp (circle)

Sweets / Extras: ________ calories/day

3. ***Referral to other health care providers:***

Name of Agency	*Date of Contact*	*Reason for Referral*

E. *Counseling on nutritional/dietary management of nutrition-related medical conditions*

***Intervention #1*: ____**

***Goal (s)*:____**

____

____

***Intervention #2*:**

____

Goal (s):____

____

____

<u>Nutrition Monitoring and Evaluation</u>

____

____

____

____

____

American Dietetic Association Nutrition Monitoring and Evaluation Terminology for Overweight Children

***Note the codes provided below are suggestions. Assess for appropriateness and revise/add as necessary.**

Nutrition Related Behavioral-Environmental Outcomes	Food and Nutrient Intake Outcomes	Nutrition Related Physical Sign/Symptom Outcomes	Nutrition Related Patient/Client Centered Outcomes
Beliefs and Attitudes: Readiness to change: BE 1.1.1	Energy Intake: Total energy intake: FI 1.1.1	Body composition/Growth: Body Mass Index (BMI): S 1.1.1	Nutrition Quality of Life: Psychological factors: PC 1.1.3
Food and Nutrition Knowledge: Level of knowledge: BE 1.2.1	Food intake: Number of food group servings: FI 2.2.2	Body Composition/Growth: Weight/weight change: S 1.1.4	Nutrition Quality of Life: Self image: PC 1.1.4
Behavior: Ability to plan meals/snacks : BE 2.1.1	Fat and cholesterol intake: total fat: FI 5.1.1	Glucose Profile: Glucose, fasting: S 2.5.1	Nutrition Quality of Life: Self efficacy: PC 1.1.5
Behavior: Ability to select healthful meals/food: BE 2.3.1	Carbohydrate intake: sugar : FI 5.3.2	Lipid Profile: Cholesterol S 2.6.1	Nutrition Quality of Life: Social/interpersonal factors: PC 1.1.6
Goal Setting: goal setting ability : BE 2.5.1	Carbohydrate intake: total carbohydrates : FI 5.3.1	Lipid Profile: HDL cholesterol (S 2.6.2); LDL cholesterol (S 2.6.3)	Nutrition Quality of Life: Nutrition quality of life score: PC 1.1.7
Self Monitoring: self monitoring ability: BE 2.81	Fiber intake: total fiber: FI 5.4.1	Lipid profile: Triglycerides: S 2.6.4	
Physical Activity: consistency and frequency: BE 4.3.1	Mineral/element intake: 6.2	Respiratory Quotient: RQ : S 2.10.1	

F. *Consultation with the recipient's primary care provider*

Name of Health Care Team Member	*Date of Contact*	*Primary Care Provider (yes / no)*	*Method of Contact (i.e. fax, mail, phone)*

G. *Education on reading food labels*

Handout Used: ______________________________ ***Date:*** ____________________

List of handouts given:____
____
____
____

Counselor's Signature ____

Date________________________ _____ ***Unit (s)***, _____ ***Minutes***

ICD-9 Codes: ____