Michelle Shelfer RD|LDN|CEDRD
Nutrition Counseling Services
Intake Form

Name: ______________________________

Date of Birth: _________________________

Health Insurance: ______________________

Please list any In-Patient/Out-Patient facilities, dietitians, and counselors you have been in treatment with:

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Do you wish to allow me to have contact with any of the above mentioned people? ______ **YES** _______ **NO**

What is your goal in seeing me for nutritional counseling?

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My policies include: (Please initial at the end if you agree)

1. Payment (cash, check, credit card) is due at the beginning of each session. _____
2. A 24 hr. cancellation notice is required to not be charged for your session. _____
3. Each session will be 45-60 min., depending upon needs. ______
4. I do occasionally use a sliding scale and would like the cost of your session to be kept confidential. _____

I, __________________________, understand and have read this intake form.