

ARIZONA NUTRITION SPECIALISTS



KRISTINE J. SCHIRM M.S., R.D.

Registered Dietitian/Nutrition Therapist

1. **APPOINTMENTS:** Schedule or cancel appointments by e-mailing me @ kschirmrd@cox.net or by calling 623-551-8783 to leave a message. I will return your message within 24 hours either by phone or e-mail.
2. **CANCELLATION OF APPOINTMENTS:** If it is necessary for you to cancel an appointment, please give me **24 hours notice** so I can make the time available to others who need to see me. If you miss an appointment, I will need to charge you my full fee for the time slot that you had reserved. To cancel appointments you must call 24 hours before your scheduled appointment to avoid being charged for the full fee.
3. **FINANCIAL AGREEMENT:** The fee for all of my professional time will be billed at a rate of \$30.00/15minute time increments. (\$60.00/30 min and \$120.00/60 minutes). This time includes report preparation or review, letters on your behalf, phone calls (of more than 10 minutes in duration). **All clients must pay in full at the beginning of each session.** For work outside my office, such as house calls, I charge my individual rate "door to door" - that is, for the time I am out of the office on your behalf.
4. **INSURANCE COVERAGE:** In general, most insurance companies do not reimburse for nutrition therapy services. In rare occasion that an insurance carrier will reimburse, it is your responsibility to communicate with your insurance company regarding amounts paid, amount of co-pays, etc. If in fact your insurance company does not pay for nutrition services, it is the client's responsibility to pay for all fees due.
5. **CONFIDENTIALITY:** In all matters having to do with your nutrition therapy, confidentiality will be maintained unless you have signed a written "Release of Information" to a specific individual or agency. A release of information from your therapist, physician, and psychiatrist should be signed before beginning nutrition therapy. You are asked to also keep confidential the identity of any client seen here or any information about them acquired in any group nutrition therapy settings.
6. **PHONE CALLS:** If you need to talk with me at a time other than your scheduled appointment time, you may call me at 623-551-8783 (message only) between the hours of 9:00 a.m. and 5:00 p.m. Monday-Friday. I will return your call within 24 hours. The first 5 minutes is free. Additional time will be charged at the rate of my hourly fee. Please note that after 6:00 p.m. I do not regularly check my voice mail and calls after 6:00 p.m. will be returned the next day.
7. **NOTICE OF TERMINATION:** You may choose to terminate nutrition therapy at any time. However, it is best that you discuss your decision with your therapist first and then give me one session's notice. A clean ending is best for both of us.
8. **WHAT TO EXPECT FROM NUTRITION THERAPY:** In our sessions you will learn about nutrition and normal eating and how to implement these concepts into daily living and eating patterns. Nutrition therapy is meant to be challenging. Therefore, it is important to understand that learning to eat normally may require making minor changes, frequently. If at any time you feel uncomfortable or are unwilling to make recommended changes, please share this with me. A food diary is an essential component to the nutrition therapy process. You will be expected to keep foods records on an ongoing and regular basis. Subsequent to each appointment a progress note will be sent to your therapist (unless you request otherwise).
9. **Contract:** I have read the Outline of Clinical Practice and I accept responsibility for the financial agreement and issues of confidentiality.

Client Name:

Date:



KRISTINE SCHIRM M.S., R.D.
REGISTERED DIETITIAN/NUTRITION THERAPIST
Arizona Nutrition Specialists
9449 N 90th St., Suite 210
Scottsdale, AZ 85258
623-551-8783
kschirmrd@aznetnutrition.com
www.learnmealplanning.com

No Show Policy

I have a new policy in place re: no shows. This is necessary as I am working only 3 days/week and am currently maintaining a waiting list. The first time a client no-shows or does not give 24 hours notice to cancel, a 1/2 hourly fee charge will be assessed (\$60.00).

The second time a client no shows, a full priced session charge of \$ 120.00 will be assessed.

The third time a client no-shows, he or she will be discharged from my practice.

In addition, clients who accrue a balance of more than \$100.00 will be required to pay this balance (or make payments towards that balance, at my discretion) before any additional sessions will be scheduled.

Thank-You in advance for your cooperation with these new policies.

Kristine Schirm M.S., R.D.

I have read and understand the no show policy for Kristine Schirm M.S.,R.D.

Patient name

Date

KRISTINE SCHIRM M.S., R.D.
REGISTERED DIETITIAN/NUTRITION THERAPIST
9449 N 90th St., Suite 210
Scottsdale, AZ 85258
623-551-8783
kschirmrd@aznetnutrition.com
www.learnmealplanning.com

MEDICAL NUTRITION THERAPY- Initial Consultation

Name:	
Date:	
Phone: (day)	
Phone: (cell)	
Email:	
Address:	
Age:	
Height:	
Weight:	
Medications:	
Supplements:	
Occupation:	

Physician Name:	
Address:	
Phone:	Fax:

3

Therapist name:
Address:
Phone:

Reason for Consultation/Chief Complaint:

Previous Eating Disorder Treatment: (Please include approximate dates)

Living Situation:

What I hope to get out of Nutrition therapy:

Weight history: (within last 2 years)

Height: _____

Current weight/date: _____

Highest weight/date: _____

Lowest weight/date: _____

Desired weight: _____

Weight losses/gains in past year (no. pounds time frame): _____

Usual weight: _____

What do you think you would weigh if recovered _____

Family weight history: (describe)

Mother:

Father:

Sister(s):

Brothers(s):

Who do you think you take after the most? _____

Dieting History: (List all diets you have been on with approximate dates, duration)

Medical History: (Please place a check next to all that apply)

I have recently been treated for the following: (Explain)

Severe vomiting
Severe diarrhea
Dehydration
Electrolyte disturbances
Chest pain
EKG abnormalities
Low heart rate (≤ 60)
Irregular heart rate
Dizziness-lightheadedness
Severe constipation
Tooth problems
Severe recent weight loss or gain
Low weight
Blood in vomit
Esophageal problems
Reflux
Severe abdominal pain
Lack of or loss of menstruation

Other:

I have a history of the following:

I am a cigarette smoker (How much and how many?)
I am either a male over 45 years or a female over 55 years old.
I do not exercise much. (Describe)
My doctor tells me I am overweight/underweight (Describe)
I have high cholesterol (Describe)
I have a family history of cardiovascular disease (Describe)
I have a family history of diabetes (Describe)
I have a history of high blood pressure (Describe)
I have chest pain
I have shortness of breath
My heart has irregular beats
I have a history of fainting/see spots/blacking out
I get dizzy from sitting to standing position (Describe)
I have a history of kidney or liver problems (Describe)
I have swelling in my extremities (Describe)
I struggle with dehydration
I have hair loss/ breakage
I have peach fuzz on my body
I am intolerant to cold (Describe)
I have documented osteopenia or osteoporosis
I feel tired a lot
I have a history of irregular labs
I am often dehydrated
I have sore/enlarged glands in my cheeks, neck or jawline
I have lesions in my throat or esophagus
I have nausea
I have abdominal bloating (Describe)
I am often constipated
I have frequent diarrhea
I have food allergies (Describe)
I have dental problems that impair my ability to chew or swallow. (Describe)

Menstrual History:

Last menstrual period (duration): _____
Are you on birth control? Y _____ N _____ Describe: _____
Do you have a history of amenorrhea? Y _____ N _____ Describe: _____
Approximate weight where period stopped: _____ Describe: _____
Have you ever had a bone density study? _____
Do you take supplemental calcium or Vit D? _____

Eating History:

I go off and on diets
I am unable to eat socially
I struggle with grocery shopping
I am afraid to eat certain foods
I restrict food
I skip meals
I do not eat between meal snacks
I restrict fluids
I water load instead of eat
I have eating rituals
I have "tricks" to suppress my appetite
I take diet pills
I take diuretics
I use laxatives
I use Ipecac
I use drugs
I drink alcohol
I use enemas
I abuse caffeine
I weight myself a lot
I am generally dissatisfied with my weight.
I body check
I compare my weight to others
I ignore my hunger cues
I have episodes where I overeat
I binge eat (feel out of control)
I eat compulsively
I binge and purge
I binge eat but do not purge
I vomit after small or normal amounts of food
I purge only after I binge
I restrict during the day and binge at night
I chew and spit food out
I eat in a hurry
I eat standing up
I eat in my car
I eat while watching t.v.
I eat according to the clock
I feel the need to finish it all "clean plate club"
I eat to reward self
I eat to punish myself
I stop eating before I feel satisfied
I do not know when I am hungry
I do not have a sense of fullness
I do not know when I am satisfied

TYPICAL DAY OF EATING:

please be specific with portion sizes, include fluids consumed with each meal and snack
please circle if meal was a binge and place a "p" next to any foods purged

Wake: (time) _____

Breakfast: (time) _____

Snack: (time) _____

Lunch: (time) _____

Snack: (time) _____

Dinner: (time) _____

Snack (time) _____

Are weekend patterns the same? If no, explain:

My primary **binge foods** are:

My primary **eating rituals** are:

My primary **protein** sources are:

My primary **vegetable** sources are:

My primary **fruit** sources are:

My primary **dairy** sources are:

My primary **carbohydrate** sources are:

My primary **fat** sources are:

8

Name your primary **fiber** sources

Name your primary sources of **sweets**:

Name your primary **restaurant** choices: (Include coffee shops, fast food)

Exercise History:

I have to exercise everyday

I exercise to compensate for what I ate

Exercise Routine: (type of exercise, frequency, duration)

Outpatient Nutrition Treatment Goals

The patient will:

- Be honest
- Keep honest and accurate food and mood journals.
- Complete all written assignments assigned by RD
- Learn how to eat a healthy, well balanced meals that include all foods in each food group
- Consume appropriate calories, fluids for meeting nutrition and hydration needs and weight goals as prescribed by R.D.
- learn appropriate portion sizes to meet nutritional needs
- Increase variety of foods in diet as prescribed by R.D.
- Identify negative triggers and learn effective coping skills
- Identify food rituals and learn effective coping skills
- Improve general nutrition knowledge and specific knowledge about eating disorders
- Reintroduce fear foods into regular meal plan
- Consistently consult with a therapist while working with R.D. (in order to remain in nutrition therapy).
- Comply with requests for laboratory work-ups with M.D.
- Discontinue purging via self-induced vomiting, exercise, laxatives, diuretics, Ipecac, _____.
- Recognize and consistently work on decreasing ritualistic food behaviors by practicing social eating and or restaurant eating challenges on a weekly basis.
- Ask for support at mealtimes and refrain from discussing food issues at meals.
- Develop a healthy exercise program appropriate for physical status as deemed appropriate by treatment team.
- Demonstrate improved knowledge and increased insight into core issues related to the eating disorder.
- Report a decreased obsession with food, fat and weight.

Method of Measurement

- A progression towards and/or maintenance of the identified healthy weight goal and corresponding BMI will be observed.
- Patient will begin to accept necessary adjustments to meal plan, which will include caloric adjustments and reintroduction of feared foods.
- A pattern of controlled healthful food intake will be observed.
- Patient will be able to demonstrate the understanding of meal planning and portioning.
- A decrease in the amount of time thinking about food, hunger and weight will be observed.
- Improvements in laboratory values will be observed.
- Normal bowel function will be achieved and maintained.
- Pt. will be able to recognize and verbalize the physical consequences of their eating disorder.
- Verbally own food fears and rituals as they occur and demonstrate a willingness to change behaviors.
- Be able to verbalize connections between emotions and eating disordered behaviors.
- Patient will demonstrate increased confidence in eating with family, friends and in restaurants.

Provider/Teacher Actions

- Provide nutritional education regarding meal planning, nutritional needs and exercise planning.
- Provide suggestions and adjustments that healthfully coincide with personal preferences.
- Monitor physical signs of healing and recovery and advise patient of progress or decline as well as make recommendations for goal progress.
- Assist in addressing food fears, food rituals and strong emotions documented at meals and snacks.
- Teach methods of tracking distorted thinking and triggering events by using cognitive logs.
- Provide 1:1 education, support to develop healthy life skills.
- Encourage the patient's confrontation of food fears by teaching and supporting the "reframing" of negative or erroneous thoughts.
- Assist with the identification of resources and support for on-going recovery.

_____ Patient to remain in therapy throughout nutrition therapy process.

_____ Follow-up with PCP for ongoing monitoring physical status and of lab values.

_____ Release of information signed for) PCP, therapist, psychiatrist).

_____ Copy of assessment and care plan provided to pt.

Patient Signature _____

RD _____

Date: _____



Nutrition Recommendations

Name:

KRISTINE SCHIRM M.S., R.D.
ARIZONA NUTRITION SPECIALISTS
REGISTERED DIETITIAN/ NUTRITION THERAPIST
9449 N 90th St., Suite 210
Scottsdale, AZ 85258
623-551-8783
kschirmrd@aznetnutrition.com
www.learnmealplanning.com