



## Welcome to Essential Nutrition!

I'm excited to begin working with you!

### PLEASE BRING WITH YOU TO OUR APPOINTMENT:

1. **Completed Medical, Nutrition, & Health assessment form** (pages 11-15), along with your **completed 3-to-7-day food journals** (pages 16-18).
2. **Bottles of dietary supplements** you are currently taking (or considering taking) which may include any of the following examples: multivitamin, fish oil supplement, protein powders, dietary fiber supplements, antioxidant formulas, etc. The bottles are required so that the specific amounts and forms of the various nutrients can be known.
3. **Authorization for Release of Information form** if you would like any of your healthcare practitioners or family members to have legal access to your nutrition records (page 3). We cannot disclose anything to anyone unless this form is signed with the appropriate information.
4. **Acknowledgement Confirming Receipt of HIPAA Privacy Notice**, signed and dated (page 7).
5. **Payment Preference** completed (page 8).
6. **Blood-work results** from doctor visits. You can call your doctor and request that copies be faxed to 303-546-0047, Attn: Lisa Lanzano, MS, RD; or Jane Reagan, MEd.
7. **Family members, significant others, or friends** who may be supporting you on making these dietary changes. There is no additional charge for their attendance.

**Driving directions** to the office are contained within this packet.

Please let us know if you have any questions.  
Please call for most recent price information.

### Special Note:

If time is of the essence,  
the highlighted areas  
are the most important  
to complete.



## Essential Nutrition Inc Office Policies

**SCHEDULING APPOINTMENTS:** To schedule or change an appointment, **please call: 303-952-5077 or 1-888-714-3777**. This is a voicemail service, not an active phone line. Please leave your message and our assistant, Kailu (Ky-loo), will return your call as soon as possible to schedule you.

**PAYMENT FOR SERVICES:** Payment in full is required at time of service unless other arrangements have been made ahead of time. We accept cash, check, Visa, MasterCard, and Discover. We do NOT currently accept American Express. **Please make checks payable to: Essential Nutrition Inc.** We prefer payment by check whenever possible. If there is any difficulty in making payment at the time of visit, please discuss this with Lisa Lanzano, MS, RD ahead of time. Should you need a refund, please note that all credit card payments are subject to a 15% no-refundable processing fee. Additionally, all service packages expire after 6 months of inactivity.

**CANCELLATIONS:** We understand unforeseen events arise that may prevent you from making your scheduled appointment. However, missing an appointment is a loss to everyone. Kindly provide at least 24-hours notice if you need to cancel an appointment, or payment in full will be required for the time slot that was reserved for you. We will be happy to reschedule you.

**INSURANCE COVERAGE:** Unfortunately, most insurance companies do not cover nutrition appointments, even when they are doctor-prescribed. Hopefully, this will change in the future. In the meantime, it is advised that you contact your insurance company to inquire about any Dietitian/Nutrition-related services you qualify for under your plan. Essential Nutrition Inc. is considered an out-of-network provider, and we will provide you with a receipt of payment that includes your ICD-9 Diagnosis code, which you may submit to your insurance company for full or partial reimbursement (assuming you qualify for such). It is the patient's responsibility to provide payment in full at time of service and then request reimbursement from the insurance company.

**CONTACTING OTHER HEALTH CARE PROVIDERS:** If you would like us to contact any of your healthcare practitioners to share health-related information about you, please fill out the attached **Authorization for Release of Information form** and bring it with you to the appointment. Include the names of any and all healthcare providers whom you would like me to contact. (such as primary care MDs, chiropractors, therapists, etc) By law, we cannot disclose anything to anyone unless this form is signed with the appropriate names (this applies to anyone age 18 years and older.)

**CONFIDENTIALITY:** All information disclosed within sessions is confidential as outlined in the HIPAA notice of Privacy Practices. Copies of HIPAA are available in this packet, as well as online at: [www.EssentialNutrition.com/contact](http://www.EssentialNutrition.com/contact). Additional copies can be made available during your office visit.

**OFFICE HOURS:** Office hours are Monday through Friday, and twice a month on Saturdays. Please call (303) 952-5077 to reserve an appointment time. Office hours may vary. Call for latest office hour information.

**CONTACTING YOUR PROVIDER:** If you leave a message by voicemail, all attempts will be made to return your call by the next business day. **If your call has not been returned within 48 hours, please call back, as it means your call was not received.** Occasionally, voicemails left from mobile phones get scrambled or dropped. We look forward to speaking with you, so please try your call again. Otherwise, we will return your call just as soon as possible. We look forward to working with you soon!

Sincerely,

*Lisa, Jane, & the Essential Nutrition team*



# Authorization for Release of Information

Please list any and all individuals with whom you allow your health information to be shared. Without the name(s) of the specific person(s), Essential Nutrition Inc. can not legally discuss any information about you with anyone, including your spouse, medical doctor, therapist, etc.

I, \_\_\_\_\_, authorize and request **Lisa Lanzano, MS, RD, or Jane Reagan, MEd,** or \_\_\_\_\_ (other RD or nutrition practitioner working with Essential Nutrition Inc.), at 4730 Walnut Street, Suite 212, Boulder, Colorado, 80301, to disclose information to the following individual(s), as it relates to my medical, nutritional, and/or health information and treatment. It is my understanding that this information is to be used for treatment planning or consultation.

NAME	RELATION	PHONE No. or EMAIL
_____	_____	_____
_____	_____	_____

The information to be released may include, specifically:

- ( ) A complete copy of my medical/health records.
- ( ) A summary of my medical/health records.
- ( ) A copy of a portion of my medical record pertaining to: \_\_\_\_\_  
Specific condition

It is agreed that no legal responsibility or liability shall attach to the healthcare provider or his or her employee acting upon this request. This consent expires in ONE YEAR from date in signature line below, unless otherwise specified here: \_\_\_\_\_ and is subject to revocation at any time under the provisions of Federal Regulations (42 C.F.R. Part 2) except to the extent that action has already been taken thereon.

All disclosures, both oral and written, made as granted by this consent shall be accompanied by the following notice: "This information has been disclosed to us from records whose confidentiality is protected by Federal Law. Federal Regulations (42 C.R.R. Part 2) prohibit us from making any further disclosures of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for release of medical records or other information is NOT sufficient for this purpose."

Signature of patient: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of parent/guardian\*: \_\_\_\_\_ Date: \_\_\_\_\_

*\*If patient is under 18 years of age, then consent must be executed b said patient AND his/her parent or guardian authorized under Colorado law to act in his/her behalf.*

**The following names are those that I have given written permission to contact, in case of emergency, or for therapeutic consultation only:**

	NAME	PHONE NUMBER
Emergency:	_____	_____
Family:	_____	_____
Therapist:	_____	_____
Psychiatrist:	_____	_____
Family Doctor:	_____	_____
Other Healthcare Practitioner:	_____	_____



### HIPAA NOTICE OF PRIVACY PRACTICES

Effective Date: 04/14/03

**THIS NOTICE DESCRIBES HOW PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

If you have any questions about this notice, please contact: Essential Nutrition Inc. and Lisa Lanzano, MS, RD, President and owner, 4730 Walnut Street, Suite 212, Boulder, CO 80301, phone 303-952-5077, fax 303-546-0047, e-mail [lisa@essentialnutrition.com](mailto:lisa@essentialnutrition.com).

**OUR PLEDGE REGARDING PROTECTED HEALTH INFORMATION:**

We, Essential Nutrition Inc., understand that protected health information about you and your health is personal. We are committed to protecting health information about you. This Notice applies to all of the records of your care generated by Essential Nutrition Inc., whether made by Essential Nutrition Inc. personnel or your personal doctor.

This Notice will tell you about the ways in which we may use and disclose protected health information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of protected health information. The law requires us to:

- make sure that protected health information that identifies you is kept private;
- notify you about how we protect protected health information about you;
- explain how, when and why we use and disclose protected health information;
- follow the terms of the Notice that is currently in effect.

We are required to follow the procedures in this Notice. We reserve the right to change the terms of this Notice and to make new notice provisions effective for all protected health information that we maintain by:

- posting the revised Notice in our office
- making copies of the revised Notice available upon request;
- posting the revised Notice on our Web site.

**HOW WE MAY USE AND DISCLOSE PROTECTED HEALTH INFORMATION ABOUT YOU.**

The following categories describe different ways that we use and disclose protected health information without your written authorization.

**For Treatment.** We may use protected health information about you to provide you with, coordinate or manage your medical treatment or services. We may disclose protected health information about you to doctors, nurses, technicians, medical students, or other Essential Nutrition Inc. personnel who are involved in taking care of you.

Essential Nutrition Inc. staff may also share protected health information about you in order to coordinate the

different things you need, such as prescriptions, lab work and x-rays. We also may disclose protected health information about you to people outside Essential Nutrition Inc. who may be involved in your medical care, such as clergy or others we use to provide services that are part of your care.

We may use and disclose protected health information to contact you as a reminder that you have an appointment for treatment or medical care at Essential Nutrition Inc. We may use and disclose protected health information to tell you about or recommend possible treatment options or alternatives or health-related benefits or services that may be of interest to you.

**For Payment for Services.** We may use and disclose protected health information about you so that the treatment and services you receive at Essential Nutrition Inc. may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may need to give your health plan information about nutrition services you received at Essential Nutrition Inc. so your health plan will pay us or reimburse you for the service. We may also tell your health plan about the nutrition services you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.

**For Health Care Operations.** We may use and disclose protected health information about you for Essential Nutrition Inc. health care operations, such as our quality assessment and improvement activities, case management, coordination of care, business planning, customer services and other activities. These uses and disclosures are necessary to run the facility, reduce health care costs, and make sure that all of our patients receive quality care.

For example, we may use protected health information to review our treatment and services and to evaluate the performance of the dietitian who is providing your services. We may also combine protected health information about many Essential Nutrition Inc. patients to decide what additional services Essential Nutrition Inc. should offer, what services are not needed, and whether certain new treatments are effective. We may also disclose information to doctors, nurses, technicians, medical students, and other Essential Nutrition Inc. personnel for review and learning purposes. We may also combine the protected health information we have with protected health information from other health care facilities to compare how we are doing and see where we can make improvements in the care and services we offer. We may remove information that identifies you from this set of protected health information so others may use it to study health care and health care delivery without learning who the specific patients are. We may also contact you as part of a fundraising effort.

Subject to applicable state law, in some limited situations the law allows or requires us to use or disclose your



health information for purposes beyond treatment, payment, and operations. However, some of the disclosures set forth below may never occur at our facilities.

**As Required By Law.** We will disclose protected health information about you when required to do so by federal, state or local law.

**Research.** We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information

**Health Risks.** We may disclose protected health information about you to a government authority if we reasonably believe you are a victim of abuse, neglect or domestic violence. We will only disclose this type of information to the extent required by law, if you agree to the disclosure, or if the disclosure is allowed by law and we believe it is necessary to prevent or lessen a serious and imminent threat to you or another person.

**Judicial and Administrative Proceedings.** If you are involved in a lawsuit or dispute, we may disclose your information in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made, either by us or the requesting party, to tell you about the request or to obtain an order protecting the information requested.

**Business Associates.** We may disclose information to business associates who perform services on our behalf (such as billing companies;) however, we require them to appropriately safeguard your information.

**Public Health.** As required by law, we may disclose your protected health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

**To Avert a Serious Threat to Health or Safety.** We may use and disclose protected health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

**Health Oversight Activities.** We may disclose protected health information to a health oversight agency for activities authorized by law. These activities include audits, investigations, and inspections, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

**Law Enforcement.** We may release protected health information as required by law, or in response to an order or warrant of a court, a subpoena, or an administrative request. We may also disclose protected health information in response to a request related to identification or location of an individual, victims of crime, decedents, or a crime on the premises.

**Organ and Tissue Donation.** If you are an organ donor, we may release protected health information to

organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

**Special Government Functions.** If you are a member of the armed forces, we may release protected health information about you if it relates to military and veterans activities. We may also release your protected health information for national security and intelligence purposes, protective services for the President, and medical suitability or determinations of the Department of State.

**Coroners, Medical Examiners, and Funeral Directors.** We may release protected health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose protected health information to funeral directors consistent with applicable law to enable them to carry out their duties.

**Correctional Institutions and Other Law Enforcement Custodial Situations.** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release protected health information about you to the correctional institution or law enforcement official as necessary for your or another person's health and safety.

**Worker's Compensation.** We may disclose information as necessary to comply with laws relating to worker's compensation or other similar programs established by law.

**Food and Drug Administration.** We may disclose to the FDA, or persons under the jurisdiction of the FDA, protected health information relative to adverse events with respect to drugs, foods, supplements, products and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

### **YOU CAN OBJECT TO CERTAIN USES AND DISCLOSURES**

Unless you object, or request that only a limited amount or type of information be shared, we may use or disclose protected health information about you in the following circumstances:

- We may share with a family member, relative, friend, or other person identified by you protected health information directly relevant to that person's involvement in your care or payment for your care. We may also share information to notify these individuals of your location, general condition or death.
- We may share information with a public or private agency (such as the American Red Cross) for disaster relief purposes. Even if you object, we may still share this information if necessary for the emergency circumstances.

If you would like to object to use and disclosure of protected health information in these circumstances, please call or write to our contact person listed on page 1 of this Notice.



### **YOUR RIGHTS REGARDING PROTECTED HEALTH INFORMATION ABOUT YOU**

You have the following rights regarding protected health information we maintain about you:

**Right to Inspect and Copy.** You have the right to inspect and copy protected health information that may be used to make decisions about your care. Usually, this includes medical and billing records.

To inspect and copy protected health information that may be used to make decisions about you, you must submit your request in writing to Lisa Lanzano, MS, RD. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request, and we will respond to your request no later than 30 days after receiving it. There are certain situations in which we are not required to comply with your request. In these circumstances, we will respond to you in writing, stating why we will not grant your request and describe any rights you may have to request a review of our denial.

**Right to Amend.** If you feel that protected health information we have about you is incorrect or incomplete, you may ask us to amend or supplement the information.

To request an amendment, your request must be made in writing and submitted to Lisa Lanzano, MS, RD. In addition, you must provide a reason that supports your request. We will act on the/ your request for an amendment no later than 60 days after receiving the request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request, and will provide a written denial to you. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the protected health information kept by Essential Nutrition Inc.;
- Is not part of the information which you would be permitted to inspect and copy; or
- We believe is accurate and complete.

**Right to an Accounting of Disclosures.** You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of protected health information about you.

To request this list or accounting of disclosures, you must submit your request in writing to Lisa Lanzano, MS, RD. You may ask for disclosures made up to six years before your request (not including disclosures made before April 14, 2003). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We are required to provide a listing of all disclosures except the following:

- For your treatment

- For billing and collection of payment for your treatment
- For health care operations
- Made to or request by you, or that you authorized
- Occurring as a byproduct of permitted use and disclosures
- For national security or intelligence purposes or to correctional institutions or law enforcement regarding inmates
- As part of a limited data set of information that does not contain information identifying you

**Right to Request Restrictions.** You have the right to request a restriction or limitation on the protected health information we use or disclose about you for treatment, payment or health care operations or to persons involved in your care.

We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment, the disclosure is to the Secretary of the Department of Health and Human Services, or the disclosure is for one of the purposes described on pages 4-5.

To request restrictions, you must make your request in writing to Lisa Lanzano, MS, RD.

**Right to Request Confidential Communications.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you must make your request in writing to Lisa Lanzano, MS, RD. We will accommodate all reasonable requests.

**Right to a Paper Copy of This Notice.** You have the right to a paper copy of this Notice at any time by contacting Lisa Lanzano, MS, RD.

### **OTHER USES AND DISCLOSURES**

We will obtain your written authorization before using or disclosing your protected health information for purposes other than those provide for above (or as otherwise permitted or required by law). You may revoke this authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your information, except to the extent that we have already taken action in reliance on the authorization.

### **YOU MAY FILE A COMPLAINT ABOUT OUR PRIVACY PRACTICES**

If you believe your privacy rights have been violated, you may file a complaint with Lisa Lanzano, MS, RD or file a written complaint with the Secretary of the Department of Health and Human Services. A complaint to the Secretary should be filed within 180 days of the occurrence or action that is the subject of the complaint. If you file a complaint, we will not take any action against you or change our treatment of you in any way.



# Acknowledgement Confirming Receipt of HIPAA Privacy Notice

I acknowledge I have received a copy of Essential Nutrition Inc's HIPAA Privacy Notice. Please sign and date below and bring this with you to your scheduled initial appointment.

\_\_\_\_\_  
Patient/Client Signature

\_\_\_\_\_  
Date

## Special Note Regarding Dietetic Interns

### Please Read

Essential Nutrition Inc. offers educational opportunities for nutrition students to occasionally observe and/or participate in nutrition counseling sessions. These are individuals who are gaining the experience they need to meet university standards to become Registered Dietitians and/or nutritionists. The same HIPAA rules and regulations apply to students as they do to all medical practitioners: your health and personal information will NOT be shared or discussed without your prior written consent.

Your comfort level with having such a student present is of utmost importance. Please check the box that corresponds with your preference regarding dietetic interns present during your session(s):

- No, I prefer NOT to have a student present at this time.
- Yes, I am comfortable having a nutrition intern observe and/or participate in our session(s), but ONLY as it relates to discussion of the following conditions:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

- Yes, I am completely comfortable having a nutrition intern observe and/or participate in our session.

\_\_\_\_\_  
Patient/Client Signature

\_\_\_\_\_  
Date

**PLEASE BRING THIS PAGE WITH YOU TO YOUR APPOINTMENT. WE NEED THIS TO BE PLACED IN YOUR FILE. PLEASE MAKE A COPY FOR YOUR RECORDS, IF NEEDED.**



# Payment Preference

By signing below, I understand that I am responsible for payment to Essential Nutrition Inc on the day of my appointment. In choosing the credit or debit card payment option, this signature authorizes the use of my card to pay for the session, and I agree to the terms below.

Signature \_\_\_\_\_

Date \_\_\_\_\_

Please Print Name \_\_\_\_\_

Payment is due the day of your appointment. Please select your payment preference:

Pay with check or cash (please remember to bring this to your appointment)

Pay with credit, debit, or health savings account debit card

Payment with cash or check is preferred, as credit card companies charge for processing, and it helps us keep our costs down. Should you forget your cash or checkbook, your credit or debit card will be charged ONLY for the date of the scheduled appointment. All cards are processed through a secure merchant account, and Essential Nutrition Inc will show up on your credit card statement. A receipt of payment will be mailed to you. Failure to show for a scheduled appointment, or cancellation without proper advance notice, will result in a charge in full to your card.

Name as it appears on card (please print legibly): \_\_\_\_\_

Card type:  Visa  Mastercard  Discover

Card number: \_\_\_\_\_ Expiration date: \_\_\_\_\_

CVV/CSC/Security code \_\_\_\_\_

(The last 3 or 4 digits that are not part of your card number, located on back of card in signature area.)

Billing Address for this card:

Street \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP/Postal code \_\_\_\_\_

Address where receipt should be mailed (if different from above)

Street \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP/Postal code \_\_\_\_\_

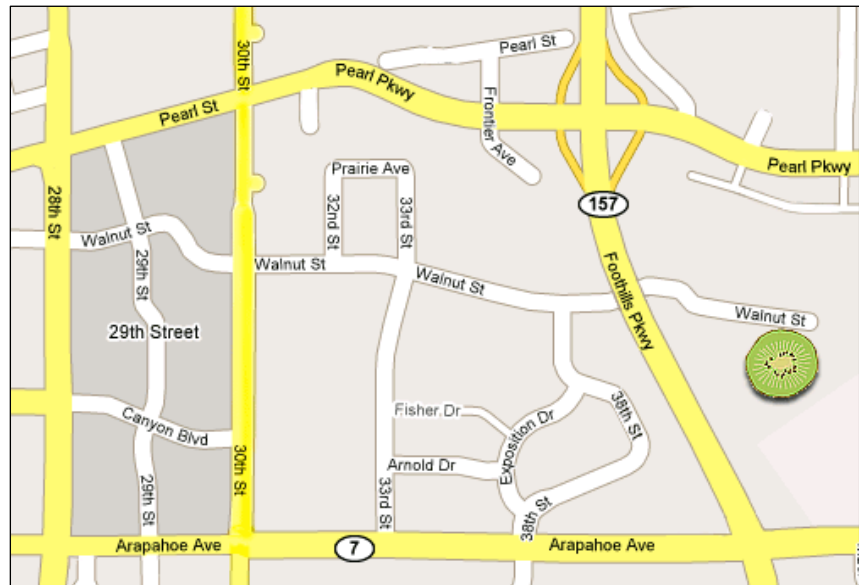
Phone number \_\_\_\_\_ Email \_\_\_\_\_

I would like to receive a superbill for each service to submit to insurance.



### Driving Directions

**Essential Nutrition Inc.**  
4730 Walnut Street  
Suite 212  
Boulder, Colorado 80301



#### FROM BOULDER:

1. Take 30th street to Walnut.
2. Turn right (East) onto Walnut (heading away from the mountains).
3. Go 0.65 miles (you will go underneath the bridge/overpass) and take the **THIRD (3<sup>rd</sup>)** right into the Tierra Center parking lot, **with the WW Reynolds For Lease sign in front** (If you take the 2<sup>nd</sup> driveway after the overpass, this will bring you to the backside of the building).
4. Turn right into the parking lot, and drive straight in.
5. I am the 2nd building on the right, #4730.
6. My office door, suite 212, is just to the left of Office Evolution, suite #108 (which is easier to identify). Lisa Lanzano, MS, RD appears as the last name on the door. Come inside and I am the very first door just to the right at the top of the stairs.

#### FROM DENVER:

1. Take Foothills Parkway to Arapahoe. Turn left onto Arapahoe (heading west).
2. The first light you come to after turning onto Arapahoe is 38th street (Marine Street to the south). Turn right onto 38th, heading north.
3. Take 38th until it ends at Walnut Street. Turn right, heading east, onto Walnut.
4. Go 0.2 miles (you will go underneath the bridge/overpass) and you will see an office complex to your right, called the Tierra Center. Take the **THIRD (3<sup>rd</sup>)** right into the Tierra Center parking lot, **with the WW Reynolds For Lease sign in front** (If you take the 2<sup>nd</sup> driveway after the overpass, this will bring you to the backside of the building).
5. Turn right into the parking lot, and drive straight in.
6. I am the 2nd building on the right, #4730.
7. My office door, suite 212, is just to the left of Office Evolution, suite #108 (which is easier to identify). Lisa Lanzano, MS, RD appears as the last name on the door. Come inside and I am the very first door just to the right at the top of the stairs.



## Specialties

Lisa Lanzano, MS, RD

Lisa@EssentialNutrition.com

- **Relationships with Food/Eating Disorders** – Anorexia, Bulimia, Emotional Eating
- **Managing Blood Sugar Naturally**—Diabetes, Insulin Resistance, Hypoglycemia, Gestational Diabetes
- **Weight Management** —Non-“Diet” Approach to Healthy Weight Management
- **Food Allergies/Celiac Disease**— Wheat & Gluten Intolerance, Food Allergies, Elimination Diets
- **Women’s Health**—PMS, Infertility, Polycystic Ovarian Syndrome, Pregnancy, Lactation
- **Sports Nutrition** – Diet and meal planning for endurance events and optimizing workouts
- **Heart Health**—High Cholesterol, High Blood Pressure, High Triglycerides, Inflammation
- **Head Injury Recovery** –Optimal Nutrition for Recovery from Auto-Accidents, Sports Injuries, and Other Brain-related Injuries

Jane Reagan, MEd

Jane@EssentialNutrition.com

- **Parents, Kids and Food**—Healthy meal ideas, feeding picky eaters, increasing fruit and vegetable intake
- **Weight Management**—Non-“Diet” Approach to Healthy Weight Management
- **Pregnancy and Lactation**
- **Heart Health**—High Cholesterol, High Blood Pressure, High Triglycerides, Inflammation
- **Managing Blood Sugar Naturally**—Diabetes, Insulin Resistance, Hypoglycemia, Gestational Diabetes
- **Family Meal Planning**



Medical Nutrition & Health Questionnaire

Date

Please answer the following questions. Some may not apply and may be left unanswered. Please be as thorough and specific as possible.

Personal Information

Form with fields for Full Name, Nickname, Date of Birth, Address, City, State, ZIP, Home Phone, Work Phone, Mobile Phone, Email, SS#, Marital Status, and two open text areas for describing reasons for seeking services and biggest nutritional challenges.

Weight History

Form with a table for weight history (Height, Current Weight, How long at weight, Do you feel healthy) and three open text areas for describing weight history, successful strategies, and unsuccessful strategies.



Lifestyle Factors

<b>WORK</b> Occupation		How many hours per week do you work?	
<b>HOME</b> If you have kids, list their names, ages, and genders here		Do any of your family members have special needs? If so, who? Describe their situation.	
<b>PHYSICAL ACTIVITY</b> Type		Duration Hours / Minutes	
Intensity <input type="checkbox"/> Low <input type="checkbox"/> Moderate <input type="checkbox"/> High	Frequency (times/week)	Are you consistent? <input type="checkbox"/> Yes <input type="checkbox"/> No	Regardless of your exercise program, are you sedentary for most of the day? <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>SLEEP</b> Average hours of sleep per night		Do you awake feeling well rested? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you often have trouble falling asleep? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have sleep apnea? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	If you have sleep apnea, is it being treated? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you wake up at night? <input type="checkbox"/> Yes <input type="checkbox"/> No How many times?	If you know why, please explain.		
<b>STRESS</b> Do you have an unusually high amount of stress in your life? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Sometimes			
Do you have appropriate outlets for coping & dealing with stress? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Sometimes			
Describe your current stress-reduction methods (such as meditation, yoga, breathing).		Most of your stress is due to what?	

Personal Medical History

Do you have or have you ever had:			
<input type="checkbox"/> Diabetes Type: _____	<input type="checkbox"/> Heart attack	<input type="checkbox"/> Food allergies/sensitivities Explain: _____	
<input type="checkbox"/> Heart disease	<input type="checkbox"/> Cancer Type: _____	<input type="checkbox"/> Lactose intolerant	
<input type="checkbox"/> Pregnant	<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Celiac disease	
<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Drug abuse	<input type="checkbox"/> Auto-immune disorder Explain: _____	
<input type="checkbox"/> Hypoglycemia	<input type="checkbox"/> Chronic constipation	<input type="checkbox"/> Other Explain: _____	
<input type="checkbox"/> Post-menopausal	<input type="checkbox"/> Sleep apnea		
<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Migraines		
<input type="checkbox"/> Stroke	<input type="checkbox"/> Shortness of breath		
<input type="checkbox"/> Eating disorder Type: _____	<input type="checkbox"/> Thyroid disorder		
Do you frequently experience:			
<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Colds/flu	<input type="checkbox"/> Muscle twitches	<input type="checkbox"/> Tingling in fingers/toes
<input type="checkbox"/> Constipation	<input type="checkbox"/> Water retention	<input type="checkbox"/> Irregular periods (females only)	<input type="checkbox"/> PMS
<input type="checkbox"/> Bloating/gas	<input type="checkbox"/> Sinus problems	<input type="checkbox"/> Bleeding gums	<input type="checkbox"/> Low immune system (frequent illnesses)
<input type="checkbox"/> Dry skin	<input type="checkbox"/> Headaches	<input type="checkbox"/> Easy bruising	<input type="checkbox"/> Nausea
<input type="checkbox"/> Heartburn/reflux	<input type="checkbox"/> Allergies	<input type="checkbox"/> Canker sores	<input type="checkbox"/> Cracks on corners of lips
<input type="checkbox"/> Light-headed/dizzy	<input type="checkbox"/> Mood swings	<input type="checkbox"/> Brittle nails	
Do you smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, what type?	If yes, how much (how often, how many)?	Do you want to quit? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
Describe your current and past use of diuretics, diet pills, and laxatives.			



### Current Medical Information

Primary Care Physician (PCP)		Phone
Referring Practitioner (if different from PCP)		Phone
<b>LABWORK</b> Total cholesterol	LDL	HDL
Cholesterol/HDL ratio	Triglycerides	Homocysteine
Blood Pressure	C-Reactive Protein	Lp(a)
Glucose	HgA1c	Other labs
Current medications (prescription & over-the-counter), dietary supplements & herbs:		
Has anyone informed you of drug-nutrient interactions for your prescriptions medications? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, what have you been told?

### Family Medical History

Has anyone in your family experienced:		
<input type="checkbox"/> Diabetes Type: _____	<input type="checkbox"/> Thyroid disorder	<input type="checkbox"/> Celiac disease
<input type="checkbox"/> Heart disease	<input type="checkbox"/> Heart attack	<input type="checkbox"/> Other
<input type="checkbox"/> Stroke	<input type="checkbox"/> Cancer Type: _____	Explain: _____
<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Alcoholism	_____
<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Drug abuse	_____

### Food and Eating

#### Food Frequency

How often do you eat the following foods? Check the appropriate box next to each food.

Never	Once a Month	Once a Week	2 to 4 times a Week	Daily		Never	Once a Month	Once a Week	2 to 4 times a Week	Daily	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fruit & fruit juices	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Poultry
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vegetables & vegetable juices	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eggs
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Soy/soy foods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Condiments
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nuts/seeds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Butter/Margarine
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nut butters (i.e. peanut butter)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Olive oil/canola oil
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Beans/legumes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other fats/oils
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dairy/calcium-rich foods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fried foods
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Snack/junk food	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Desserts
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	"White" processed foods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Candy/soda
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Whole grains	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fish	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Caffeine
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Red Meat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Water/Other beverages



### A Typical Day's Food Intake

In the appropriate column below, write down the typical foods you eat from day to day. Include everything that passes your lips, including fluid intake and solid foods. Also record portion sizes according to the Portion Size chart below.

	Weekdays	Weekends
Breakfast		
Morning Snack		
Lunch		
Afternoon Snack		
Dinner		
Evening Snack		
Midnight Snack		

### Portion Sizes



**1 cup**  
about the size of a tennis ball



**1 oz.**  
about the size of a 1-inch cube or a pair of dice



**3 oz. cooked meat, fish, poultry**  
about the size of a deck of cards or your palm



**1 roll or piece of cornbread**  
about the size of a bar of soap



**1 teaspoon**  
about the size of your thumb pad



**1/4 cup**  
about the size of a golf ball



How long have you been eating like this? \_\_\_\_\_

Do you eat like this consistently?  Yes  No

Have you recently made any changes to your diet?  Yes  No

If so, what are they? \_\_\_\_\_

When did you implement these changes? \_\_\_\_\_

Are you conscious of what and how much you put in your mouth?  Yes  No  Sometimes

Are you an emotional eater?  Yes  No  Sometimes

How often do you your emotions drive you to eat? \_\_\_\_\_

Do you eat more on days that you're overly stressed?  Yes  No

How often do you feel overly stressed? \_\_\_\_\_

Do you eat more when you're tired?  Yes  No  Sometimes

How often are you lacking sleep and feeling tired? \_\_\_\_\_

Are you often ravenous before meals?  Yes  No

Are you often overly full at the end of a meal?  Yes  No

How many meals do you eat AT home each week (include breakfast, lunch & dinner)? \_\_\_\_\_

How many meals do you eat AWAY from home each week? \_\_\_\_\_

Which meals do you most often eat AWAY from home?  Breakfast  Lunch  Dinner

Do you like to cook?  Yes  No

Do you feel you eat a wide variety of foods?  Yes  No  Unsure

Do you drink enough water throughout the day?  Yes  No  Unsure

Do you feel bored with the foods you eat?  Yes  No  Sometimes

Do you have a history of following fad diets?  Yes  No

If yes, which ones have you followed? \_\_\_\_\_

What are your overall nutritional goals? \_\_\_\_\_

How ready and willing are you to make the changes necessary for achieving your goals?

Not at all  
Ready or Willing

Slightly Ready  
& Willing

Fairly Ready  
& Willing

Very Ready  
& Willing

0

1

2

3

4

5

6

7

8

9

10

How did you hear about Essential Nutrition? \_\_\_\_\_



### Food Frequency

Place a checkmark in the column to indicate how often you eat that food

Foods	Never	<1x/Month	<1x/Week	2-4x/Week	Daily
Fruit & fruit juices					
Vegetables & vegetable juices					
Dairy/Calcium-rich foods					
Soy/soy foods					
Nuts/seeds					
Nut butters (e.g., peanut butter)					
Beans/legumes					
Snack/Junk food					
“White” processed foods					
Whole grains					
Fish					
Red Meat					
Poultry					
Eggs					
Condiments					
Butter/Margarine					
Olive oil/canola oil					
Other fats/oils					
Fried foods					
Desserts					
Candy/soda					
Alcohol					
Caffeine					
Water/Other beverages					



### Instructions for Completing a Food Diary

1. Write down everything you eat or drink for 3-7 days (the greater number of days completed, the more accurate the information will be). Remember to write down everything that passes your lips, including small "tastes" of foods, beverages, or snacks.
2. Measure and record the amounts of food served in common portion sizes, such as cups, teaspoons, tablespoons, or describe the size as accurately as you can (for example, one large banana, 8" long)
3. Indicate how the food was prepared: fried, steamed, raw, in sauce (name the type of sauce), in oil (name the type of oil, if known), etc.
4. Be as specific as possible. Instead of "turkey sandwich" say, "turkey sandwich with 2 slices Orowheat 100% wheat bread, 4 oz. deli smoked turkey breast, 1 Tablespoon mayonnaise, 2 slices tomato, 2 iceberg lettuce leaves."
5. List brand names of all food products, for example, Quaker Instant Oatmeal, or McCann's Steel Cut Irish Oats.
6. Be sure to record all the little extras: candies, salad dressings, croutons, jelly, sugar, ketchup, butter, etc. Indicate amounts as accurately as possible.
7. Include recipes for any unusual items you prepare at home.
8. It is advised to write down foods as soon after you consume them as possible, to improve accuracy of record keeping.

### Common Household Items as Portion Management Aids



**1 cup**  
about the size of a tennis ball



**1 oz.**  
about the size of a 1-inch cube or a pair of dice



**3 oz. cooked meat, fish, poultry**  
about the size of a deck of cards or your palm



**1 roll or piece of cornbread**  
about the size of a bar of soap



**1 teaspoon**  
about the size of your thumb pad



**1/4 cup**  
about the size of a golf ball



Food Journal

Hr	Amt	Food	Hunger*		Emotional State, Activity, and Thoughts
			Before	After	

\*Hunger Scale:      1                      2                      3                      4                      5  
 Empty      Slight Hunger      Neutral      Comfortable      Stuffed

Fluids:



Total:

Fruit	Veg	Starch	Dairy	Protein	Fat	Junk