



## **NUTRITION AND INTEGRATIVE HEALTH ADULT QUESTIONNAIRE**

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### **INSTRUCTIONS FOR YOUR FIRST NUTRITION CONSULTATION**

THANK YOU FOR TAKING THE TIME TO THOUGHTFULLY ANSWER THE QUESTIONS IN THIS NEW CLIENT QUESTIONNAIRE. YOU'LL HAVE AMPLE OPPORTUNITY TO ADDRESS ANY CONCERNS THAT REQUIRE MORE DETAIL DURING YOUR APPOINTMENT.

#### **REQUIRED FOR YOUR FIRST VISIT:**

1. THE COMPLETED NEW CLIENT QUESTIONNAIRE, ALONG WITH THE 3-DAY DIET DIARY INCLUDED IN THE QUESTIONNAIRE.

#### *INSTRUCTIONS FOR COMPLETING THE 3-DAY DIET DIARY:*

- RECORD INFORMATION AS SOON AS POSSIBLE AFTER THE FOOD HAS BEEN CONSUMED. PLEASE INCLUDE ALL BEVERAGES, EVEN WATER.
  - DO NOT CHANGE YOUR EATING BEHAVIOR AT THIS TIME UNLESS YOUR DOCTOR ADVISES YOU TO. THE PURPOSE OF THIS FOOD RECORD IS TO ANALYZE YOUR PRESENT EATING HABITS.
  - DESCRIBE THE FOOD OR BEVERAGE CONSUMED. E.G., MILK - WHAT KIND? (WHOLE, 2%, OR NONFAT); TOAST - (WHOLE WHEAT, WHITE, BUTTERED); CHICKEN - (FRIED, BAKED, BREADED), ETC.
  - RECORD THE AMOUNT OF EACH FOOD CONSUMED USING STANDARD MEASUREMENTS AS MUCH AS POSSIBLE, SUCH AS 8 OUNCES, 1/2 CUP, 1 TEASPOON, ETC.
  - INCLUDE ANY ADDITIONAL ITEMS (I.E. CONDIMENTS). FOR EXAMPLE: TEA WITH 1 TEASPOON SUGAR, POTATO WITH 2 TEASPOONS BUTTER, ETC.
2. PRIOR TO YOUR VISIT, PLEASE SEND ANY LABS, BLOOD TESTS OR OTHER PERTINENT MEDICAL INFORMATION YOU THINK MAY BE HELPFUL TO: [MINDY@THEMINDFULHEARTLLC.COM](mailto:MINDY@THEMINDFULHEARTLLC.COM)

#### **PLEASE BRING THE FOLLOWING:**

- ANY PHARMACEUTICALS, OVER-THE-COUNTER DRUGS, AND/OR SUPPLEMENTS YOU ARE TAKING – PLEASE BRING THEM IN THEIR ORIGINAL CONTAINERS SO MINDY CAN DETERMINE WHAT INGREDIENTS AND AMOUNTS ARE IN THE PRODUCTS.

**IF YOU HAVE ANY QUESTIONS PLEASE CONTACT US: [MINDY@THEMINDFULHEARTLLC.COM](mailto:MINDY@THEMINDFULHEARTLLC.COM)**



## NUTRITION

### ADULT QUESTIONNAIRE

**PLEASE ALLOW 30-45 MINUTES TO COMPLETE MOST OF THIS QUESTIONNAIRE. THE 3-DAY DIET DIARY WILL REQUIRE YOU TO RECORD YOUR FOOD AND BEVERAGE INTAKE OVER A 3-DAY PERIOD. PLEASE ANSWER THE QUESTIONS BELOW AS THOROUGHLY AS POSSIBLE SO THAT WE MAY MAKE THE BEST POSSIBLE CLINICAL ASSESSMENT. THIS HELPS US DEVELOP A REALISTIC AND WORKABLE PLAN FOR SUPPORTING YOU IN REACHING YOUR HEALTH GOALS. YOUR ANSWERS TO PERSONAL QUESTIONS SUCH AS RELATIONSHIP STATUS, RELIGION, ETC. ARE IMPORTANT AS THEY PROVIDE HELPFUL CONTEXT FOR ESTABLISHING A PRODUCTIVE PARTNERSHIP WITH YOU. THAT SAID; PLEASE ANSWER ONLY THE QUESTIONS YOU ARE COMFORTABLE ANSWERING.**

#### BASIC INFORMATION

PRIMARY PHYSICIAN'S NAME:

PHYSICIAN OFFICE NUMBER:

PHYSICIAN ADDRESS:

PHYSICIAN FAX NUMBER:

TODAY'S DATE:

CONTACT INFORMATION							
NAME:			ADDRESS:				
WORK PHONE:			HOME PHONE:				
MOBILE PHONE:			EMAIL:				
PREFERRED CONTACT METHOD:			BEST TIME(S) OF DAY TO REACH YOU:				
EMERGENCY CONTACT							
NAME:		RELATIONSHIP:			PHONE:		
OCCUPATION & INTERESTS							
OCCUPATION:		HOW LONG?		SATISFIED? (1-10)			
WHAT ARE YOUR INTERESTS/PASSIONS:							
DEMOGRAPHICS							
AGE	DATE OF BIRTH	GENDER	RACE	ETHNICITY			
HEIGHT:	WEIGHT LBS.	HIGHEST ADULT WEIGHT	LBS. / YR.:	LOWEST ADULT WEIGHT	LBS. / YR.:		
RELATIONSHIP INFORMATION							
STATUS		PARTNER'S NAME:					
PERSONAL INFORMATION							
RELIGION:		EDUCATION:					

WITH WHOM (PERSONS OR ANIMALS) DO YOU SHARE YOUR HOME?

WHAT TYPES OF HEALTH PRACTITIONERS ARE YOU CURRENTLY WORKING WITH?

WHAT ARE YOUR PRIMARY REASONS FOR SEEKING NUTRITION AND INTEGRATIVE HEALTH SERVICES?

- 1.
- 2.
- 3.

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### **MEDICAL INFORMATION**

WHAT HEALTH CONCERNS DID YOU EXPERIENCE AS A CHILD?

WHAT HEALTH CONCERNS HAVE YOU EXPERIENCED AS AN ADULT?

HAS YOUR DOCTOR DIAGNOSED YOU WITH A MEDICAL CONDITION (S)? IF SO, PLEASE LIST:

ARE YOU PART OF A RECOVERY PROGRAM? IF SO, WHICH ONE?

DO YOU HAVE ANY ALLERGIES TO FOODS, MEDICATIONS, CHEMICALS, AND/OR OTHER ENVIRONMENTAL SUBSTANCES?  
IF SO, TO WHICH ONES?

WHAT IS YOUR TYPICAL REACTION AND HOW SEVERE IS IT (1-10)?

WHAT, IF ANY, SURGERIES/OPERATIONS HAVE YOU UNDERGONE, AND WHEN?

HAVE YOU EVER BEEN HOSPITALIZED FOR REASONS OTHER THAN SURGERIES/OPERATIONS?  
IF SO, WHEN AND FOR WHAT REASON(S)?

HAVE YOU EVER HAD A MAJOR CHEMICAL EXPOSURE? IF SO, WHEN AND TO WHAT?

WHERE AND WHEN HAVE YOU LIVED OR TRAVELED OUTSIDE OF THE U.S. AND CANADA?

IS THERE ANYTHING THAT SURFACED DURING A RECENT MEDICAL TEST, LAB WORK, OR DOCTOR'S VISIT THAT YOU WOULD LIKE TO REPORT?

### **FAMILY HISTORY**

<b>RELATIONSHIP</b>	<b>ALIVE/DECEASED</b>	<b>PRESENT HEALTH OR CAUSE OF DEATH</b>
PATERNAL GRANDMOTHER		
PATERNAL GRANDFATHER		
MATERNAL GRANDMOTHER		
MATERNAL GRANDFATHER		
FATHER		
MOTHER		
BROTHERS		
SISTERS		

CHILDREN/AGES		
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**MEDICATIONS & SUPPLEMENTS**

CURRENT MEDICATIONS (OVER-THE-COUNTER AND PRESCRIPTION)				
NAME	DOSAGE	FREQUENCY	LENGTH OF TIME	REASON FOR TAKING

WHAT MEDICATION HAVE YOU TAKEN IN THE PAST FOR A CONSIDERABLE AMOUNT OF TIME?

CURRENT DIETARY OR HERBAL SUPPLEMENTS					
NAME	BRAND	DOSAGE	FREQUENCY	LENGTH OF TIME	REASON FOR TAKING

**FOR WOMEN**

PREGNANCIES (PLEASE INCLUDE LOSSES/TERMINATIONS)			
YEAR	VAGINAL/C SECTION	SEX	COMPLICATIONS/OTHER THINGS YOU WANT TO MENTION

ARE YOU CURRENTLY PREGNANT?  
ARE YOU BREASTFEEDING?

ARE YOU ACTIVELY TRYING TO CONCEIVE?

PHYSICAL ACTIVITY					
	FREQUENCY				COMMENTS
	MONTHLY	WEEKLY	DAILY	MULTIPLE TIMES A DAY	
ACTIVE LIFESTYLE					EXAMPLES?
CARDIO TYPE EXERCISE					WHAT TYPE(S)?
STRENGTH BUILDING EXERCISE					WHAT TYPE(S)?
STRETCHING					WHAT TYPE(S)?
HOW WOULD YOU CATEGORIZE YOUR ACTIVITY LEVEL?	SEDENTARY		MILDLY ACTIVE	MODERATELY ACTIVE	
	ACTIVE		VERY ACTIVE	INTENSELY ACTIVE	

SLEEP	
AT WHAT TIME ARE YOU TYPICALLY IN BED?	
WHAT TIME DO YOU FALL ASLEEP?	
TYPICAL HOURS ASLEEP?	
# OF TIMES YOU AWAKEN DURING THE NIGHT	



## METABOLIC SCREENING QUESTIONNAIRE

Use this questionnaire to chart your health and progress. Rate each of the following symptoms based on your health for the past thirty days.

### Point Scale:

0 = Never or almost never have the symptom.  
1 = Occasionally have it; effect is not severe.  
2 = Occasionally have it; effect is severe.  
3 = Frequently have it; effect is not severe.  
4 = Frequently have it; effect is severe.

The Medical Symptom Questionnaire was developed by Jeffrey Bland, PhD.

### **Digestive Tract**

Nausea or vomiting  
Diarrhea  
Constipation  
Bloated feeling  
Belching or passing gas  
Heartburn

#### **Total**

### **Ears**

Itchy ears  
Earaches, ear infections  
Drainage from ear  
Ringing in ears, hearing loss

#### **Total**

### **Emotions**

Mood swings  
Anxiety, fear, or nervousness  
Anger, irritability or aggressiveness

#### **Total**

### **Energy/Activity**

Fatigue, sluggishness  
Apathy, lethargy  
Hyperactivity  
Restlessness

#### **Total**

### **Eyes**

Watery or itchy eyes  
Swollen, reddened, or sticky eyelids  
Bags or dark circles under eyes  
Blurred or tunnel vision  
Slurred speech

#### **Total**

### **Mouth/Throat**

Chronic coughing  
Gagging, frequent need to clear throat  
Sore throat, hoarseness, loss of voice  
Swollen or discolored tongue, gums, lips  
Canker sores

#### **Total**

### **Nose**

### **Head**

Headaches  
Faintness  
Dizziness  
Insomnia

#### **Total**

### **Heart**

Irregular or skipped heartbeat  
Rapid or pounding heartbeat  
Chest Pain

#### **Total**

### **Joints/Muscles**

Pain or aches in joints  
Arthritis  
Stiffness or limitation in movement  
Pain or aches in muscles  
Feeling of weakness or tiredness

#### **Total**

### **Lungs**

Chest congestion  
Asthma, bronchitis  
Shortness of breath

#### **Total**

### **Mind**

Poor memory  
Confusion, poor comprehension  
Poor concentration  
Difficulty in making decisions  
Stuttering or stammering  
Learning disabilities

#### **Total**

### **Skin**

#### **Acne**

Hives, rashes, or dry skin  
Hair Loss  
Flushing or hot flashes  
Excessive sweating

#### **Total**

### **Weight**

Binge eating/drinking

### **Other**

Frequent illness

Stuffy nose  
 Sinus problems  
 Hay fever  
**DISCHARGE**  
 Sneezing attacks  
 Excessive mucus formation  
**Total**

Craving certain foods  
 Excessive weight  
 Compulsive eating  
 Water retention  
 Underweight  
**Total**

Frequent or urgent  
 urination  
**GENITAL ITCH OR**  
  
**Grand Total**

**SYMPTOM QUESTIONNAIRE** PLEASE PLACE YES OR NO AFTER EACH QUESTION.

**SECTION 1**

INDIGESTION, BURPING, BLOATING OR SLEEPY IMMEDIATELY AFTER MEALS	
HEARTBURN OR ACID REFLUX SYMPTOMS	
TENDENCY TO ALLERGIES, ECZEMA, ASTHMA	
NAUSEA IN EVENINGS	
PROTEINS HARD TO DIGEST, COMPLEX MEALS HARD TO DIGEST (COMBINATION OF PROTEINS AND CARBS)	
LOSS OF TASTE FOR MEAT	
SENSE OF EXCESS FULLNESS AFTER MEALS	
FEEL LIKE SKIPPING BREAKFAST, OVERALL LOW APPETITE	
UNDIGESTED FOOD IN STOOL	
ANEMIA, UNRESPONSIVE TO IRON	

**SECTION 2**

HEARTBURN OR ACID REFLUX SYMPTOMS	
NAUSEA IN MORNINGS	
STRONG APPETITE, DEMANDING HUNGER, EXCESS SALIVATION	
AGGRAVATED BY SPICE OR SOUR, SOUR BURPS, SOUR SMELL	

**SECTION 3**

PAIN BETWEEN SHOULDER BLADES	
STOMACH UPSET BY FATTY OR FRIED FOODS	
LOOSE STOOLS WITH FATTY FOODS, IRREGULAR STOOLS, FAT IN STOOLS (SHINY, FLOATING), SMELLY STOOLS	
NAUSEA	
LIGHT, CLAY COLORED OR GREENISH/YELLOW STOOLS	
DRY SKIN, ITCHY FEET OR SKIN PEELS ON FEET	
GALLBLADDER ATTACKS	
GALLBLADDER REMOVED	
BITTER TASTE IN MOUTH, ESPECIALLY AFTER MEALS	
EASILY INTOXICATED OR HUNG IF YOU WERE TO DRINK WINE	
PAIN UNDER RIGHT SIDE OF RIB CAGE	
HEMORRHOIDS OR VARICOSE VEINS	
SENSITIVE TO CHEMICALS (PERFUME, CLEANING AGENTS, ETC.), DIESEL FUMES OR TOBACCO SMOKE	

**SECTION 4**

FOOD ALLERGIES OR SENSITIVITIES (WHEAT OR GRAIN, OR DAIRY OR OTHER)	
FREQUENT INTAKE OF ALLERGENIC FOOD (S), STRONG ATTACHMENT TO ALLERGENIC FOODS	
CRAVING, ADDICTION OR BINGING OF ALLERGENIC FOODS (S)	
ABDOMINAL BLOATING 1-2 HOURS AFTER EATING	
PULSE SPEEDS UP AFTER EATING	
CROHN'S DISEASE, FREQUENT SINUS INFECTION, MIGRAINES, ASTHMA	
AIRBORNE ALLERGIES	
EXPERIENCE HIVES	

**SECTION 5**

CATCH COLDS AT THE BEGINNING OF WINTER	
FREQUENT COLDS, FLU OR OTHER INFECTIONS (SINUS, EAR, BLADDER, SKIN, ETC.)	

EXPERIENCED A MUCOUS PRODUCING COUGH  
 NEVER GET SICK  
 HISTORY OF EPSTEIN BAR, MONO, HERPES, SHINGLES, CHRONIC FATIGUE SYNDROME, HEPATITIS,  
 OR OTHER CHRONIC VIRAL CONDITIONS  
 HAVE FOOD ALLERGIES OR SENSITIVITIES

**SECTION 6**

COATING ON YOUR TONGUE  
 ANUS ITCHES  
 FUNGUS OR YEAST INFECTIONS  
 YEAST SYMPTOMS INCREASE WITH SUGAR, STARCH OR ALCOHOL CONSUMPTION  
 LESS THAN ONE BOWEL MOVEMENT A DAY  
 CONSTIPATION, STOOLS HARD OR DIFFICULT TO PASS  
 EXCESSIVE FOUL SMELLING LOWER BOWEL GAS  
 IRRITABLE BOWEL OR MUCOUS COLITIS  
 BAD BREATH OR STRONG BODY ODOR  
 CRAMPING IN LOWER ABDOMINAL REGION  
 STOOLS ARE DIFFICULT TO PASS  
 HISTORY OF PARASITES  
 STOOLS HAVE CORNERS OR EDGES, ARE FLAT AND RIBBON SHAPED

**SECTION 7**

EAT LESS THAN FIVE SERVINGS OF (ONE-HALF CUP COOKED, 1 CUP RAW) OF COLORED VEGETABLES  
 OR FRUITS A DAY  
 CRAVE SWEETS, BREADS, ROLLS, COOKIES, PASTA, PIZZA OR CHIPS  
 CRAVE COFFEE OR SUGAR IN THE AFTERNOON  
 SLEEPY IN THE AFTERNOON  
 FATIGUE IS RELIEVED BY EATING  
 BINGING OR UNCONTROLLED EATING  
 EXCESSIVE APPETITE  
 WHEN YOU EAT SNACKS/SWEETS, DO YOU EAT THEM, GET A TEMPORARY BOOST OF ENERGY AND MOOD,  
 AND LATER CRASH?  
 HEADACHE, IRRITABILITY OR SHAKINESS IF MEALS ARE SKIPPED OR DELAYED  
 HEART PALPITATIONS AFTER EATING SWEETS  
 HAVE FREQUENT THIRST  
 HAVE FREQUENT URINATION  
 ONCE YOU START EATING SWEETS OR CARBOHYDRATES, DO YOU FEEL YOU CAN'T STOP  
 TEND TO GAIN WEIGHT IN THE BELLY  
 HAVE PRE-DIABETES, DIABETES, PCOS, HYPOGLYCEMIA OR ALCOHOLISM OR A FAMILY HISTORY OF  
 ANY ONE OF THESE  
 HAVE ELEVATED TRIGLYCERIDES OR CHOLESTEROL  
 HAVE HIGH BLOOD PRESSURE

**SECTION 8**

HAVE HIGH OR LOW BLOOD PRESSURE  
 HAVE A LOW LIBIDO  
 HAVE TROUBLE FALLING ASLEEP  
 GET LESS THAN 8 HOURS A SLEEP A NIGHT  
 GO TO BED FREQUENTLY AFTER MIDNIGHT  
 GET LESS THAN 1 HOUR A DAY OF SUNLIGHT  
 WORK THE NIGHT SHIFT  
 ARE YOU AN EMOTIONAL EATER  
 FEEL ANXIOUS OR HAVE PANIC ATTACKS  
 ARE YOU A SHALLOW BREATHER  
 EXPERIENCE HEART PALPITATIONS  
 CRAVINGS FOR SALT OR SWEETS  
 EXPERIENCE CHRONIC OR PROLONGED FATIGUE

DOES FATIGUE PREVENT YOU FROM DOING THINGS YOU WOULD LIKE TO DO. INTERFERE WITH YOU WORK, FAMILY OR SOCIAL LIFE	
DO YOU FEEL YOU CAN'T GET STARTED IN THE MORNING WITHOUT COFFEE OR CAFFEINATED DRINKS	

**SECTION 9**

ARE YOU COLD WHEN EVERYONE ELSE IS WARM	
HAVE COURSE OR BRITTLE HAIR	
EXPERIENCE CONSTIPATION	
HAVE THINNING HAIR OR HAIR LOSS	
EXPERIENCED A LOSS OF SEX DRIVE	
LOST THE OUTSIDE OF YOUR EYEBROW	
EXPERIENCE DEPRESSION	
HAVE TROUBLE LOSING WEIGHT	
HAVE A LOW BLOOD PRESSURE OR HEART RATE	
HAVE ELEVATED CHOLESTEROL	
HAVE A HOARSE VOICE	
HAVE DRY, SCALY SKIN	
HAVE COLD HANDS AND FEET	
EXPERIENCE FATIGUE	
EXPERIENCE FLUID RETENTION	

**SECTION 10**

AWARE OF IRREGULAR OR HEAVY BREATHING	
EXPERIENCED DISCOMFORT AT HIGH ALTITUDES	
SIGH FREQUENTLY OR "AIR HUNGER"	
HAVE SHORTNESS OF BREATH WITH MODERATE EXERTION	
EXPERIENCE SWELLING OF THE ANKLES, ESPECIALLY AT END OF DAY	
BLUSH OR FACE TURNS RED FOR NO REASON	
EXPERIENCE A DULL PAIN OR TIGHTNESS IN CHEST AND/OR RADIATE INTO LEFT ARM, WORSE ON EXERTION	
HAVE MUSCLE CRAMPS ON EXERTION	

**SECTION 11**

RARELY BREAK OUT INTO A SWEAT	
USE ALUMINUM COOKING EQUIPMENT	
HAVE MERCURY AMALGAMS	
HEAT FOOD IN PLASTIC CONTAINERS IN MICROWAVE	
HAVE YOUR CLOTHES DRY-CLEANED	
EAT "FAST-FOOD" > 2 TIMES A WEEK	
DRINK TAP, WELL OR BOTTLED WATER	
HAVE STRONG BODY ODOR	
HAVE ACNE ON FACE OR BUTTOCKS	
DRINK < 4 CUPS WATER A DAY (APPROXIMATELY 30 OZ)	
LIVE IN A LARGE URBAN OR INDUSTRIAL AREA	
USE LAWN OR GARDEN CHEMICALS	
HAVE LESS < 1 BOWEL MOVEMENT PER DAY	
REACT TO SMALL AMOUNTS OF ALCOHOL	
SIT ON YOUR COMPUTER 3+ HOURS A DAY	
EXERCISE < 3 TIMES A WEEK	
USE TOBACCO PRODUCTS	
EAT LARGE FISH (SWORD FISH, TUNA, SHARK, TILEFISH) MORE THAN ONCE A WEEK	
URINATE SMALL AMOUNTS OF DARK URINE ONLY A FEW TIMES A DAY	

FREQUENTLY EXPOSED TO SOLVENTS AND CHEMICALS AT WORK OR AT HOME  
 FEEL ANY OF THE FOLLOWING: WIRED, INCREASED ACHES IN MUSCLES AND JOINTS, ANXIETY,  
 PALPITATIONS, SWEATING, DIZZINESS WHEN USING CAFFEINE  
 HAVE A NEGATIVE REACTION WHEN YOU CONSUME FOODS CONTAINING MSG, SULFITES OR OTHER  
 PRESERVATIVES

NUTRITION FREQUENCY					
FOOD/DRINK	FREQUENCY				COMMENTS
	MONTHLY	WEEKLY	DAILY	MULTIPLE TIMES A DAY	
CAFFEINE					IN WHAT FORM?
SODA/SOFT DRINKS (DIET OR REGULAR)					WHAT TYPE(S)?
ALCOHOL					WHAT TYPE(S)?
HERB TEA					WHAT TYPE(S)?
RED MEAT					BEEF, LAMB, SAUSAGE/DELI
WHITE MEAT					POULTRY, PORK SAUSAGE/DELI
EGGS					
FISH/SHELLFISH					
NUTS & SEEDS					
FRUITS					CANNED, FROZEN, FRESH,
VEGETABLES					CANNED, FROZEN, FRESH,
LENTILS & BEANS					CANNED, FROZEN, FRESH,
OILS / FATS (E.G., OLIVE, BUTTER)					WHAT TYPE(S)?
DAIRY PRODUCTS					MILK, CHEESE, YOGURT, BUTTER
SOY PRODUCTS					WHAT TYPE(S)?
WHOLE GRAINS					WHAT TYPE(S)?
GRAIN-BASED PRODUCTS					BREAD, CRACKERS, PASTA,
”JUNK / FAST FOOD”					WHAT TYPE(S)?
FRIED FOODS					WHAT TYPE(S)?
ARTIFICIAL SWEETENERS					ASPARTAME, SUCRALOSE, EQUAL, TRUVIA

<b>CHEWING GUM</b>					<b>WHAT TYPE(S)?</b>	
<b>HOW MANY TIMES EACH WEEK DO YOU EAT EACH MEAL AT HOME (VS. OUT)?</b>				<b>BREAKFAST,</b>	<b>LUNCH,</b>	<b>DINNER</b>
<b>APPROXIMATELY HOW MANY OUNCES OF WATER DO YOU DRINK PER DAY?</b>				<b>OZ</b>	<b>BOTTLED,</b>	<b>FILTERED,</b>
				<b>TAP</b>		

<b>NUTRITION - 3-DAY FOOD DIARY</b>		
<b>RECORD INFORMATION AS SOON AS POSSIBLE AFTER THE FOOD HAS BEEN CONSUMED. PLEASE INCLUDE ALL BEVERAGES, EVEN WATER.</b>		
<b>DAY 1</b>	<b>DAY 2</b>	<b>DAY 3</b>
<b>BREAKFAST</b>	<b>BREAKFAST</b>	<b>BREAKFAST</b>
<b>SNACK</b>	<b>SNACK</b>	<b>SNACK</b>
<b>LUNCH</b>	<b>LUNCH</b>	<b>LUNCH</b>
<b>SNACK</b>	<b>SNACK</b>	<b>SNACK</b>
<b>DINNER</b>	<b>DINNER</b>	<b>DINNER</b>

SNACK	SNACK	SNACK
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***THANK YOU FOR TAKING THE TIME TO COMPLETE THIS QUESTIONNAIRE.***



**Mindy Greenside, MS, CNS, LDN**  
Nutrition and Integrative Health

### **Notice of Privacy Practices**

All patient information is handled under the HIPAA Privacy Act. The privacy of your medical information, as described in the HIPAA Privacy Act, is important to The Mindful Heart, LLC. As a client of The Mindful Heart, LLC a record of your care and services will be created. This record is required to provide you with quality care and to comply with certain legal requirements. The Mindful Heart, LLC will not use or disclose your medical information for any purpose, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to The Mindful Heart, LLC at the address below. The Mindful Heart, LLC may use medical information about you to provide you with medical treatment or services and may disclose medical information about you to doctors, nurses, or other health care providers to assist them in treating you. The Mindful Heart, LLC may use and disclose your medical information for payment purposes. A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include your medical information.

### **Services to Be Provided**

Mindy's goal is to help you achieve the highest state of health consistent with your own goals. Nutritional services can serve as an excellent adjunct to a medical doctor's treatment, but are not a substitute for that treatment. Services offered as a part of this consultation may include education about nutrition and supplements, personalized whole foods and dietary recommendations, meal plans, lifestyle modifications, nutritional supplement recommendations, such as but not limited to vitamins, minerals, herbs, amino acids and fatty acids. As a part of Medical Nutrition Therapy, Mindy Greenside will perform a comprehensive nutrition assessment determining a nutrition diagnosis; plan and implement a nutrition intervention; and monitor and evaluate your progress.

### **Client Rights and Responsibilities**

It is your responsibility to fully disclose health information to The Mindful Heart LLC. As service progresses, inform them of changes that occur, including medication and health changes. You have the right to respectful, courteous care and can refuse to follow any or all recommendations provided as a result of this consultation. You have the right to choose another practitioner for any reason and to request that health information be disclosed to another practitioner or health care provider.

### **Fees and Charges**

Payment for the consultation is due at the time services are rendered. Except in emergency situations, you will be charged for missed appointments without 24 hours notice. The initial one hour and a half consultation has a fee of \$200.00 and the follow up appointments are fifty minutes with a fee of \$125.00. The fee for missed appointments is \$100.00. Emails and phone calls longer than 10 minutes will be billed at \$25 per 15 minutes. There is a returned check fee of \$ 50.00

### **Supplement Safety**

The historical record and modern research indicate that herbs and supplements most often used for healthcare have a good safety record. Similarly, confirmed cases of herb, nutrient and drug interactions are rare. However, adverse events can occur after using any active substance, including allergic response. Therefore it is imperative that you disclose to The Mindful Heart, LLC: 1) all medications, supplements and herbs currently in use, 2) any

liver or kidney disease (past or present), 3) any allergies, 4) if you plan to become pregnant or are currently pregnant or breastfeeding. It is important to stay within the dosage recommended. You are expected to inform your physicians of any nutritional supplement or herb use. Any suggestion that the effect of a drug is being altered by simultaneous use of an herb or nutritional supplement should be reported directly to all health professionals involved. It is also advisable to stop taking herbs and supplements 7 days before and after a surgical operation, and/or in the event of being prescribed a new medication.

**Informed Consent**

I am solely responsible for the decision to see Mindy Greenside, MS, CNS, LDN, for Nutrition Counseling. I have reviewed this document, including safety of supplements, services to be provided, cancellation fees, my responsibilities as a client, and the Notice of Privacy Practices. I understand Mindy is not a physician and therefore cannot diagnose or treat disease, or prescribe drugs. If I have not already done so, I agree to consult a medical doctor for any serious or life-threatening disease conditions, either for myself or someone under my guardianship. I have had the opportunity to ask Mindy questions regarding the proposed services, this consent form, and other pertinent information and have received satisfactory explanations. I understand that I am free to discontinue service(s) at any time.

Client's Name \_\_\_\_\_

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent or Guardian Signature  
(if client is under 18 years old): \_\_\_\_\_ Date: \_\_\_\_\_

Witness/Practitioner Signature: \_\_\_\_\_ Date: \_\_\_\_\_



**CREDIT CARD AUTHORIZATION**

Card Holder Information:

Name on Card: \_\_\_\_\_

Home Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Card Number: \_\_\_\_\_

Expiration Date: \_\_\_\_\_

Three-Digit Security Code: \_\_\_\_\_

Card Type: \_\_\_\_\_ (MasterCard, Visa, Discover, American Express)

Zip Code Associated with the Credit Card: \_\_\_\_\_

“I authorize The Mindful Heart LLC to charge this credit card for each appointment unless otherwise specified.”

Cardholder Signature: \_\_\_\_\_

**The Mindful Heart LLC**  
[www.TheMindfulHeartLLC.com](http://www.TheMindfulHeartLLC.com)

**Bethesda**  
4405 East West Highway, Suite 503  
Bethesda, MD 20814

**Silver Spring**  
804 Pershing Drive, Suite 004  
Silver Spring, MD 20910

**Olney**  
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Olney, MD 20832