|  |  |  |
| --- | --- | --- |
| **First Name:** | **Last Name:** | **Date of Birth:** |
| **Prefer to be Called:** | **Marital Status: Single**  **Married**  **Partnered**  **Widowed**  **Separated** | **Age:** |
| **Street Address:** | **City:** | **State:** **Zip:** |
| **Preferred Phone: home**  **work**  **cell**  **( ) -** | **Alternate Phone: home**  **work**  **cell**  **( ) -** | **May we leave a message on your preferred phone?**  **Yes** **No** |
| **Employer:** | **Occupation:** | **SS#** |
| **Emergency Contact Name:**  **Emergency Phone(s): ( ) -** | **Preferred email:** | **Primary Care Physician:** |
| **List any drug allergies:** | **Preferred Pharmacy:** | **List any food allergies:** |

**What is your main reason for your visit today?**

**Which Services Interest You:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **🔾** | acupuncture | **🔾** | energy medicine | **🔾** | men’s health |
|  | aromatherapy |  | emotional freedom technique |  | nutritional testing |
|  | Biofeedback |  | frequency specific microcurrent |  | metabolic blueprint |
|  | bio-identical hormones |  | functional medicine |  | nutrition counseling |
|  | Bowen technique |  | food allergies testing |  | organization |
|  | Chiropractic |  | health coaching |  | rapid eye technology |
|  | craniosacral therapy |  | Healing Touch™ |  | Reiki |
|  | counseling/therapy |  | HeartMath™ |  | walk & talk therapy |
|  | detox program |  | life coaching |  | wellness |
|  | energy medicine |  | massage |  | weight loss |

**Would you like to receive our newsletter?**  **Yes**  **No** *(we will never sell your name)*

**Cancellation & Re-Scheduling Policy**

We understand that there are times when you will need to cancel and/or reschedule your appointment due to emergencies. We will do our best to accommodate your needs in such situations.

**Please know that all cancellations and/or rescheduling requests must be made at least two business days prior to the date of your appointment.** If a previously scheduled session is not cancelled or rescheduled within 24 hours of the time of the appointment, that session will be “missed” and charged for the full session fee. Thank you for your understanding.

**I understand and accept this policy**

**Your Signature Today’s Date**

**Records and Privacy Policy**: We will not release your records to anyone without your written consent. Because this is an integrated practice with multiple practitioners, we may facilitate care by having only one record per client. Coordinated care by your chosen practitioners will always be done with respect for your personal privacy and confidentiality.

**I understand and accept this policy**

|  |  |  |
| --- | --- | --- |
| **How Well Do You Sleep?**  **How Long Do You Sleep?** | **Daily Stress Level** (Please Rate)  High  Moderately High  Average  None | **Daily Energy Level** (Please Rate)  Excellent  Good  Fair  Poor |
| **Do You Exercise**?  What Type?  How Often Per Week?  For How Long? | **How Important is Religion/Spirituality to You and Your Family’s Life**?  Extremely Important  Somewhat Important  Not At All Important | **Do You Drink Alcohol?**  How Much Per Week?  Do you Flush with Alcohol Intake? |
| **Do You Use Recreational Drugs?**  How Much Per Week? | **Do You Smoke?**  How Much Per Day?  For How Many Years? | **Where have you lived and traveled?** |
| **Previous Surgery and Dates**:  Appendectomy Date: ( / / )  Hysterectomy Date: ( / / )  Tonsils/Adenoids Date: ( / / )  Breast biopsy Date: ( / / )  Back surgery Date: ( / / )  Knee surgery Date: ( / / )  Oral surgery Date: ( / / )  Cesarean Section Date: ( / / )  Tubal Ligation/Vasectomy Date: ( / / )  Other:       Date: ( / / )  Other:       Date: ( / / )  Other:       Date: ( / / )  **Previous Injuries and Dates**:  Head Injury Date: ( / / )  Neck injury Date: ( / / )  Back injury Date: ( / / )  Bones Broken Date: ( / / )  **Previous Car or Tramatic Injury**:  Head Injury:  Neck injury:  Back injury:  Bones Broken: | **Have You Been Diagnosed With:**  Anemia  Arthritis  Asthma  Bronchitis  Cancer type:  Diabetes  Epilepsy  Gallstones  Gout  Heart Attack  Heart Failure  Heart Valve Problems  Hepatitis (Liver problem)  High Blood Pressure  High Cholesterol or Triglycerides  Irritable Bowel or Colitis  Kidney Stones  Mononucleosis  Plantar Fasciitis  Pneumonia  Rheumatic Fever  Sleep Apnea  Stroke  Thyroid Problems | **Do You Have or Wear:**  Glasses  Contact lenses  Hearing Aid(s)  Dentures  Pacemaker  Artificial knee(s)  Artificial hip(s)  Other:  **How Often Have You Taken Antibiotics?**  <5 times >5times  Infancy/Childhood  Teen  Adult  **How Often Have You Taken a Course of Oral Steroids?**  <5 times >5times  Infancy/Childhood  Teen  Adult |

**NAME:****DOB:**

**Any Other Hospitalizations and Dates:**

**Please describe your personal health history:**

**Family History:** Please briefly describe any problems affecting your family below. If deceased, provide cause of death and their approximate age.

**Mother-**

**Father-**

**Mother’s Mother-**

**Mother’s Father-**

**Father’s Mother-**

**Father’s Father-**

**Sibling(s)-**

**Spouse/Significant Other-**

**Child/Children-**

**Mother’s Siblings-**

**Father’s Siblings-**

**Ob-Gyn History** *(Women Only)*

**Are your periods regular?**

**Are your periods painful and/or symptomatic?**

**Have your periods changed recently?**

**Number of pregnancies total:**

**Number of miscarriages:**

**Number of abortions:**

**Current method of contraception:**

**Date of last pap smear:** ( / / )

**Date of last mammogram/thermogram:** ( / / )

**NAME:      DOB:**

**Digestive Health**

**Do you have gas, bloating or heartburn?**

**Has your digestion changed recently?**

**If so, in what way?**

**How often do you have bowel movements?**

More than 3 times a day  1-3 times a day  4-6 times a week  1-3 times a week

**Which if any of these features describe your bowel movements?**

soft  hard  float  sink  offensive odor  blood visible  difficult to pass  watery

**With whom do you live?**

**How well have things been going for you?**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Very Well** | **Fair** | **Poor** | **Very Poor** | **Does Not Apply** |
| **With your attitude** |  |  |  |  |  |
| **In your job** |  |  |  |  |  |
| **At school** |  |  |  |  |  |
| **In your social life** |  |  |  |  |  |
| **With your close friends** |  |  |  |  |  |
| **With your spouse** |  |  |  |  |  |
| **With your boyfriend/girlfriend** |  |  |  |  |  |
| **With your parents** |  |  |  |  |  |
| **With your children** |  |  |  |  |  |
| **With sex** |  |  |  |  |  |

**Have you or your family recently experienced any major life changes?** If yes, please explain.

**NAME:      DOB:**

**Review of Symptoms: Please check if these symptoms occur presently or have occurred in the past 6 months. Note if the symptom is not applicable (n/a), mild, moderate or severe and add comments if indicated.**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **CATEGORY** | **SYMPTOM** | **SEVERITY** | | | | | | | | **COMMENTS** |
| **GENERAL** | Cold hands/feet |  | n/a |  | mild |  | moderate |  | severe |  |
| Cold intolerance |  | n/a |  | mild |  | moderate |  | severe |  |
| Daytime sleepiness |  | n/a |  | mild |  | moderate |  | severe |  |
| Difficulty falling asleep |  | n/a |  | mild |  | moderate |  | severe |  |
| Waking early |  | n/a |  | mild |  | moderate |  | severe |  |
| Fatigue |  | n/a |  | mild |  | moderate |  | severe |  |
| Flushing |  | n/a |  | mild |  | moderate |  | severe |  |
| Heat intolerance |  | n/a |  | mild |  | moderate |  | severe |  |
| Night waking |  | n/a |  | mild |  | moderate |  | severe |  |
| Nightmares |  | n/a |  | mild |  | moderate |  | severe |  |
| No dream recall |  | n/a |  | mild |  | moderate |  | severe |  |
| Distorted sense of smell |  | n/a |  | mild |  | moderate |  | severe |  |
| Distorted sense of taste |  | n/a |  | mild |  | moderate |  | severe |  |
| Ear ringing/buzzing |  | n/a |  | mild |  | moderate |  | severe |  |
| Eye crusting |  | n/a |  | mild |  | moderate |  | severe |  |
| Eye pain |  | n/a |  | mild |  | moderate |  | severe |  |
| Headache/migraines |  | n/a |  | mild |  | moderate |  | severe |  |
| Hearing loss |  | n/a |  | mild |  | moderate |  | severe |  |
| Vision problems |  | n/a |  | mild |  | moderate |  | severe |  |
| **MUSCLE** | Calf cramps |  | n/a |  | mild |  | moderate |  | severe |  |
| Chest tightness |  | n/a |  | mild |  | moderate |  | severe |  |
| Foot cramps |  | n/a |  | mild |  | moderate |  | severe |  |
| Joint deformity |  | n/a |  | mild |  | moderate |  | severe |  |
| Joint pain |  | n/a |  | mild |  | moderate |  | severe |  |
| Joint redness |  | n/a |  | mild |  | moderate |  | severe |  |
| Joint stiffness |  | n/a |  | mild |  | moderate |  | severe |  |
| Muscle pain/spasms |  | n/a |  | mild |  | moderate |  | severe |  |
| Muscle twitches: eyes |  | n/a |  | mild |  | moderate |  | severe |  |
| Muscle twitch: arms/legs? |  | n/a |  | mild |  | moderate |  | severe |  |
| Muscle weakness |  | n/a |  | mild |  | moderate |  | severe |  |
| Tendonitis |  | n/a |  | mild |  | moderate |  | severe |  |
| Tension headaches |  | n/a |  | mild |  | moderate |  | severe |  |
| TMJ |  | n/a |  | mild |  | moderate |  | severe |  |
| **MOOD** | Anxiety |  | n/a |  | mild |  | moderate |  | severe |  |
| Depression |  | n/a |  | mild |  | moderate |  | severe |  |
| Difficulty concentrating |  | n/a |  | mild |  | moderate |  | severe |  |
| Difficulty with balance |  | n/a |  | mild |  | moderate |  | severe |  |
| Difficulty with thinking |  | n/a |  | mild |  | moderate |  | severe |  |
| Difficult with followthrough |  | n/a |  | mild |  | moderate |  | severe |  |

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **CATEGORY** | **SYMPTOM** | 🔾 | | | | | | | | **COMMENTS** |
| **MOOD** | Difficulty with judgment |  | n/a |  | mild |  | moderate |  | severe |  |
| Difficulty with speech |  | n/a |  | mild |  | moderate |  | severe |  |
| Difficulty with memory |  | n/a |  | mild |  | moderate |  | severe |  |
| Dizziness |  | n/a |  | mild |  | moderate |  | severe |  |
| Fainting/light headed |  | n/a |  | mild |  | moderate |  | severe |  |
| Fearfulness |  | n/a |  | mild |  | moderate |  | severe |  |
| Irritability |  | n/a |  | mild |  | moderate |  | severe |  |
| Numbness |  | n/a |  | mild |  | moderate |  | severe |  |
| Phobias |  | n/a |  | mild |  | moderate |  | severe |  |
| Paranoia |  | n/a |  | mild |  | moderate |  | severe |  |
| Seizures |  | n/a |  | mild |  | moderate |  | severe |  |
| Suicidal thoughts |  | n/a |  | mild |  | moderate |  | severe |  |
| Eating |  | n/a |  | mild |  | moderate |  | severe |  |
| Bulimia |  | n/a |  | mild |  | moderate |  | severe |  |
| Can’t gain weight |  | n/a |  | mild |  | moderate |  | severe |  |
| Can’t lose weight |  | n/a |  | mild |  | moderate |  | severe |  |
| Carbohydrate craving |  | n/a |  | mild |  | moderate |  | severe |  |
| Poor appetite |  | n/a |  | mild |  | moderate |  | severe |  |
| Salt craving |  | n/a |  | mild |  | moderate |  | severe |  |
| **DIGESTION** | Bleeding gums |  | n/a |  | mild |  | moderate |  | severe |  |
| Bloating in abdomen |  | n/a |  | mild |  | moderate |  | severe |  |
| Blood/mucous in stool |  | n/a |  | mild |  | moderate |  | severe |  |
| Burping/flatulence |  | n/a |  | mild |  | moderate |  | severe |  |
| Canker sores |  | n/a |  | mild |  | moderate |  | severe |  |
| Cold sores |  | n/a |  | mild |  | moderate |  | severe |  |
| Constipation |  | n/a |  | mild |  | moderate |  | severe |  |
| Diarrhea |  | n/a |  | mild |  | moderate |  | severe |  |
| Difficulty swallowing |  | n/a |  | mild |  | moderate |  | severe |  |
| Dry mouth |  | n/a |  | mild |  | moderate |  | severe |  |
| Foods repeat(reflux) |  | n/a |  | mild |  | moderate |  | severe |  |
| Heartburn |  | n/a |  | mild |  | moderate |  | severe |  |
| Hemorrhoids |  | n/a |  | mild |  | moderate |  | severe |  |
| Liver disease/jaundice |  | n/a |  | mild |  | moderate |  | severe |  |
| Nausea |  | n/a |  | mild |  | moderate |  | severe |  |
| Periodontal (gum) disease |  | n/a |  | mild |  | moderate |  | severe |  |
| Strong stool odor |  | n/a |  | mild |  | moderate |  | severe |  |
| Undigested food in stools |  | n/a |  | mild |  | moderate |  | severe |  |
| Vomiting |  | n/a |  | mild |  | moderate |  | severe |  |
| **SKIN** | Acne on face |  | n/a |  | mild |  | moderate |  | severe |  |
| Athlete’s foot |  | n/a |  | mild |  | moderate |  | severe |  |
| Bumps - back upper arm |  | n/a |  | mild |  | moderate |  | severe |  |
| Cellulite |  | n/a |  | mild |  | moderate |  | severe |  |

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **CATEGORY** | **SYMPTOM** | 🔾 | | | | | | | | **COMMENT** |
| **SKIN** | Dark circles under eyes |  | n/a |  | mild |  | moderate |  | severe |  |
| Easy bruising |  | n/a |  | mild |  | moderate |  | severe |  |
| Eczema |  | n/a |  | mild |  | moderate |  | severe |  |
| Herpes |  | n/a |  | mild |  | moderate |  | severe |  |
| Hives |  | n/a |  | mild |  | moderate |  | severe |  |
| Oily skin |  | n/a |  | mild |  | moderate |  | severe |  |
| Psoriasis |  | n/a |  | mild |  | moderate |  | severe |  |
| Rash |  | n/a |  | mild |  | moderate |  | severe |  |
| Shingles |  | n/a |  | mild |  | moderate |  | severe |  |
| Skin cancer |  | n/a |  | mild |  | moderate |  | severe |  |
| Strong body odor |  | n/a |  | mild |  | moderate |  | severe |  |
| Vitiligo |  | n/a |  | mild |  | moderate |  | severe |  |
| Dryness |  | n/a |  | mild |  | moderate |  | severe |  |
| Enlarged lymph nodes |  | n/a |  | mild |  | moderate |  | severe |  |
| Fingernails bitten |  | n/a |  | mild |  | moderate |  | severe |  |
| Fingernails brittle |  | n/a |  | mild |  | moderate |  | severe |  |
| Fungus fingernails/toenails |  | n/a |  | mild |  | moderate |  | severe |  |
| White spots fingernails |  | n/a |  | mild |  | moderate |  | severe |  |
| **RESPIRATORY** | Sleep Apnea |  | n/a |  | mild |  | moderate |  | severe |  |
| Nose bleeds |  | n/a |  | mild |  | moderate |  | severe |  |
| Post nasal drip |  | n/a |  | mild |  | moderate |  | severe |  |
| Sinus infections |  | n/a |  | mild |  | moderate |  | severe |  |
| Snoring |  | n/a |  | mild |  | moderate |  | severe |  |
| Breathlessness |  | n/a |  | mild |  | moderate |  | severe |  |
| **HEART** | Heart attack |  | n/a |  | mild |  | moderate |  | severe |  |
| Heart murmur |  | n/a |  | mild |  | moderate |  | severe |  |
| High blood pressure |  | n/a |  | mild |  | moderate |  | severe |  |
| Irregular pulse |  | n/a |  | mild |  | moderate |  | severe |  |
| Mitral valve prolapse |  | n/a |  | mild |  | moderate |  | severe |  |
| Palpitations |  | n/a |  | mild |  | moderate |  | severe |  |
| Phlebitis/blood clots |  | n/a |  | mild |  | moderate |  | severe |  |
| Swollen ankles/feet |  | n/a |  | mild |  | moderate |  | severe |  |
| Varicose veins |  | n/a |  | mild |  | moderate |  | severe |  |
| Infection |  | n/a |  | mild |  | moderate |  | severe |  |
| **URINARY** | Kidney disease |  | n/a |  | mild |  | moderate |  | severe |  |
| Kidney stone |  | n/a |  | mild |  | moderate |  | severe |  |
| Leaking/incontinence |  | n/a |  | mild |  | moderate |  | severe |  |
| Pain/burning |  | n/a |  | mild |  | moderate |  | severe |  |
| Urgency |  | n/a |  | mild |  | moderate |  | severe |  |
| Prostate infection |  | n/a |  | mild |  | moderate |  | severe |  |
| **MALES** | Discharge from penis |  | n/a |  | mild |  | moderate |  | severe |  |
| Ejaculation problem |  | n/a |  | mild |  | moderate |  | severe |  |

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **CATEGORY** | **SYMPTOM** | 🔾 | | | | | | | | **COMMENT** |
| **MALES** | Genital pain |  | n/a |  | mild |  | moderate |  | severe |  |
| Lumps in testicles |  | n/a |  | mild |  | moderate |  | severe |  |
| Low libido(sex drive) |  | n/a |  | mild |  | moderate |  | severe |  |
| Breast lumps |  | n/a |  | mild |  | moderate |  | severe |  |
| **FEMALES** | Breast tenderness |  | n/a |  | mild |  | moderate |  | severe |  |
| Ovarian cyst |  | n/a |  | mild |  | moderate |  | severe |  |
| Low libido (sex drive) |  | n/a |  | mild |  | moderate |  | severe |  |
| Endometriosis |  | n/a |  | mild |  | moderate |  | severe |  |
| Fibroids |  | n/a |  | mild |  | moderate |  | severe |  |
| Infertility |  | n/a |  | mild |  | moderate |  | severe |  |
| Vaginal discharge |  | n/a |  | mild |  | moderate |  | severe |  |
| Vaginal odor |  | n/a |  | mild |  | moderate |  | severe |  |
| Vaginal itch |  | n/a |  | mild |  | moderate |  | severe |  |
| Vaginal pain |  | n/a |  | mild |  | moderate |  | severe |  |
| PMS symptoms |  | n/a |  | mild |  | moderate |  | severe |  |
| Menstrual cramps |  | n/a |  | mild |  | moderate |  | severe |  |
| Heavy periods |  | n/a |  | mild |  | moderate |  | severe |  |
| Irregular periods |  | n/a |  | mild |  | moderate |  | severe |  |
| No periods |  | n/a |  | mild |  | moderate |  | severe |  |
| Spotting between periods |  | n/a |  | mild |  | moderate |  | severe |  |

**What percentage of the food you eat is home cooked?**      %

**Please list what you usually eat for**:

**Breakfast-** **Mid Morning Snack-** **Lunch-**

**Afternoon Snack-** **Dinner-** **Desserts-**

**Have you found certain foods do not “agree with you” or cause symptoms? If so, please identify the food and symptom you have.**

**NAME:      DOB:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| MEDICATION | Mg./CC (strength) | Dosage (how much) | Date started | Date:\_\_\_\_ |
| list change |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

**NAME:      DOB:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| SUPPLEMENT | Mg./CC (strength) | Dosage (how much) | Date started | Date:\_\_\_\_ |
| list change |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

**NAME:      DOB:**

**How to Prepare for Your Functional Nutrition Visit**

Welcome to the practice of Functional Nutrition. This may be a new experience for you so let me briefly introduce you. This is about creating or restoring health through food and nutrition. The basic principles of functional nutrition are rooted in Functional Medicine - the concept that our bodies know how to create health if we restore the balance and harmony to our body, mind and spirit. We look at the body as a whole and at each person as a uniquely different “ecosystem”. To create real change in your health generally requires profound change in how you look after yourself.

There is a lot of information we collect to help us make your nutrition program and this requires a number of things. We ask you to consider your health in ways and in details you may not have done in the past. This is a completely different approach and cannot succeed without your ongoing participation.

**What to Expect at Your First Visit**

* Plan to have a detailed conversation about your specific goals for your health and to review your past health in detail. This appointment is approximately 2 full hours. You will spend the first one and a half hour with me discussing your health, goals and plans. The last half hour you will spend with Tara, my health coach, getting started on your nutrition plan.
* At the conclusion of this appointment we will decide what additional functional nutritional testing we may need to start you on your journey and also discuss what your path along this journey might look like.
* My office will provide you with the appropriate test paperwork, kits and instructions. Some kits are for you to take home and do at home. These come with postage-paid labels. You will ship these directly to the individual laboratories from your home or office.
* These tests help us determine “how your digestion, nutrition, immune and ecosystem is functioning” and give us a blueprint to create your health and nutrition plan. These tests are not meant to diagnose or treat disease.
* Tara will work with you the last half hour to get started on your path to improved nutrition. My clients often start with a detox or elimination diet while waiting for test results. We will discuss this at the appointment.

*Please bring the original bottles of all of your medication, supplements and any protein powders, fibers, etc. that you currently take. If you have previous test results please bring a copy of these tests to the appointment that you plan to leave with us.*

**What to Expect After Your First Session**

* At the lab review follow-up appointment, you will be scheduled for a one hour appointment with Betty to discuss your results and develop a plan. Then you will work with Tara for 30-minutes to create a menu and meal plan to assist you with your dietary and lifestyle changes you discussed with me.
* After each appointment I will provide you with a written plan or homework assignment. The homework will outline the next steps you are to take in working on your health and nutrition that you and I determined on your visit and will indicate when your next appointment should occur.
* During the second visit, you may discuss ongoing programs to support you on your quest for health including follow up appointment frequency, additional testing, and the Be Well Circle membership services available to you as a client of Betty’s. We are here to help you get and stay well.

**Electronic Medical Records and Email Communication**

* All of my clients are required to register and sign up for our Portal Connect online health record. The portal has an annual cost of $36. On this portal, you can upload labs from other health care providers, keep a record of your personal health history, supplements and medications, download copies of your homework, labs and handouts and **email questions to me**. Please be advised due to HIPAA requirements, emails can *only be answered through the patient portal* and not through any other email programs. Generally your questions will be answered within 24-48 hours.

Clinical Nutrition is not medical care and does not take the place of your physician. I do not diagnose, treat or manage disease. If you have a medical emergency, you should go through the usual emergency management channels.

**Office Hours**

We are available every weekday in the office from 9:00 AM to 6:00 PM central Monday through Thursday and 9:00 to 1:00pm on Friday. You may contact us by telephone or securely online through the Patient Portal.

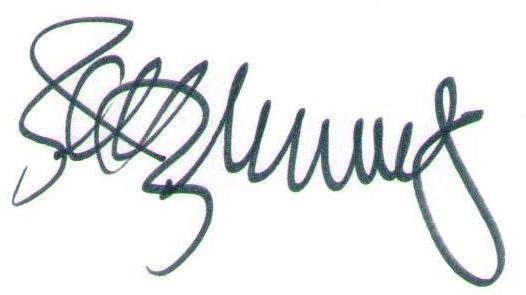
Functional Nutrition is a unique opportunity to either improve or restore your health through nutrition and lifestyle. My goal is to help you move through this process and help you accomplish what you have put on your health wish list.

**Explanation of Fees**

* Our Clinical Nutritionist fees are $200 per initial consultation and $145 for established patients follow-up office visits, telephone consultations, and email consultation responses.
* In many cases, lab test fees may be covered or partially covered by your insurance. Any out of pocket lab fees are paid directly to the lab performing the testing based on your insurance company coverage of tests. Many tests today are covered with nominal co-pay fees by most insurance carriers. If your insurance will not process the labs for you, we often can pass along discounted practitioner pricing for your nutritional testing. In those cases, lab tests are paid to our office and we give you a receipt to submit for insurance reimbursement.

Living Well Dallas is committed to helping you maximize your health and well-being. We offer our Be Well Circle membership as a value added service to support you in your dietary, lifestyle, self-care and stress management goals. Feel free to ask us at your visit about what is available to you.

In health,



Betty Murray, CN, HHC

Certified Nutritionist and Founder Living Well Dallas

**Informed Consent**

*Nutritional and Dietary Changes*

* Nutrition is a rapidly evolving science. Nutritional interventions may affect your current medication schedule and symptoms. Positive nutritional changes have a positive effect on your health but do not absolutely guarantee of either avoiding or developing disease. Nutritional interventions may help to better evaluate your health status.

*Nutritional Supplements*

* Supplements and nutritional supplements may interfere with prescribed medications. It is important that a physician is aware of what combinations of medications and supplements you are taking.

*Nutrigenomic and Functional Nutritional and Medical Assessments*

* Nutrigenomic and epigenetic assessment is a rapidly evolving science. It is an indicator of potential risk of disease development, but not an absolute guarantee of either avoiding or developing disease. Functional medicine tests and assessments may help to better evaluate your health status. However, these assessments do not diagnose disease neither and should preclude nor substitute for traditional medical care.

|  |  |
| --- | --- |
| **Signature** | **Informed Consent** |
|  | **Consent for Nutrition Services**  I am attending this nutritional consultation and working with Betty Murray, CN, HHC and or nutrition professionals at Living Well Dallas of my own volition. Living Well Dallas recommends that you inform your medical doctor of any and all dietary changes which you make as a result of her recommendations.  I understand that Betty Murray is a Certified Nutritionist and Certified Holistic Health Counselor with private licensure and the health coaches under her supervision are trained to help guide clients in improving their health through dietary and lifestyle changes. Betty Murray is not a medical doctor or registered dieticians and does not diagnose or treat disease. I take full responsibility for my health and for the decisions regarding my diet that I make as a result of the recommendations made. Any dietary supplements and nutritional recommendations are suggestions and whether or not I act on these suggestions is as a result of my own volition.  I hereby release and discharge Betty Murray and Living Well Dallas, LLC. from any and all claims that I or my family or heirs, have or may have, now or in the future. I have read and understood all of the above, and agree to proceed under these conditions. I understand that the above is meant to have legal significance and be legally binding. |