INGREDIENTS FOR HEALTH
Marina Bedrossian, RDN, CDN, CLT

Holistic Nutrition Intake

To enhance your scheduled consult time, please have this back to me at least 2 days prior to your appointment, if possible. You can scan and email to IFHnutrition@gmail.com or fax to (631) 498-1174.

General Information

Date:

Name			
Date of Birth		Age:	Gender: ☐ M ☐ F
Genetic Background	☐ African American ☐ Native American ☐ Mediterranean	☐ Hispanic ☐ Caucasian ☐ Northern European	☐ Asian ☐ Other *(please note)*
Address			
Best Phone Number	Alternate Number:		
Email			
Best Way to Reach?	☐ Phone ☐ Email		
Primary Physician	*Name:*		
	City:	*Phone:*	
Referred by			

Complaints/Concerns

What do you hope to achieve in your visit?_____

Please **rank** current/ongoing problems **by priority** and fill in the other boxes as completely as possible:

DESCRIBE PROBLEM	MILD/ MODERAT	TREATMENT APPROACH	SUCCESS
Example: Post Nasal Drip	Moderate	Elimination Diet	Moderate
a.			
b.			
c.			
d.			

When was the last time you felt well?	
Did something trigger your change in health?	

What is the lowest body weight that you have been comfortably able to maintain for at least 2 years in your adult life, since around age 30?	
Notes:	

Allergy Information

Please list FOOD allergies	
Please list NON-FOOD allergies	
What type of allergic symptoms do you experience?	

Anything you think we should know? This is the place where you can detail your main concerns and what you expect to get out of working with me:

_____

_____

_____

_____

_____

_____

_____

_____

_____

Medical History

	Height:	Weight:	Waist:

Please check those health conditions that your doctor has diagnosed (provide the date of onset)

GASTROINTESTINAL

- ☐ Irritable Bowel Syndrome
- ☐ Inflammatory Bowel Disease
- ☐ Crohn's Disease
- ☐ Ulcerative Colitis
- ☐ Gastric or Peptic Ulcer Disease
- ☐ GERD (reflux/heartburn)
- ☐ Celiac Disease
- ☐ Hepatitis C or Liver Disease
- ☐ Other Digestive:

INFLAMMATORY/AUTOIMMUNE

- ☐ Chronic Fatigue Syndrome
- ☐ Rheumatoid Arthritis
- ☐ Lupus SLE
- ☐ Poor Immune Function *(frequent infections)*
- ☐ Severe Infectious Disease
- ☐ Herpes-Genital
- ☐ Multiple Chemical Sensitivities
- ☐ Gout
- ☐ Other:

CARDIOVASCULAR

- ☐ Heart Disease (heart attack)
- ☐ Stroke
- ☐ Elevated Cholesterol
- ☐ Irregular heart rate – Pacemaker
- ☐ High Blood Pressure
- ☐ Mitral Valve Prolapse/heart murmur
- ☐ Other Heart & Vascular:

METABOLIC/ENDOCRINE

- ☐ Diabetes ☐ Type 1 or ☐ Type 2
- ☐ Metabolic Syndrome (insulin resistance)
- ☐ Hypoglycemia
- ☐ Hypothyroidism (low thyroid)
- ☐ Hyperthyroidism (overactive thyroid)
- ☐ Polycystic Ovarian Syndrome (PCOS)
- ☐ Genetic Disorder: _____
- ☐ Other:

RESPIRATORY

- ☐ Asthma
- ☐ Bronchitis
- ☐ Chronic Sinusitis
- ☐ Emphysema
- ☐ Pneumonia
- ☐ Tuberculosis
- ☐ Sleep Apnea
- ☐ Other:

MUSCULOSKELETAL/PAIN

- ☐ Osteoarthritis
- ☐ Fibromyalgia
- ☐ Chronic Pain
- ☐ Migraines
- ☐ Other:

Please note any past or current injuries:

Medical History (continued)

NEUROLOGICAL/MOOD		CANCER
☐ Depression	☐ Bipolar Disorder	☐ Cancer *(please describe type and treatment)*
☐ Anxiety	☐ ADD/ADHD	
☐ Autism	☐ Multiple Sclerosis	
☐ Seizures	☐ Memory Problems	
☐ Eating Disorder	☐ Other:	

OTHER *(use separate sheet if necessary)*

☐ Kidney stones	☐ Anemia	Please any other diseases or health conditions
☐ Eczema	☐ Urinary (UTIs)	
☐ Psoriasis	☐ Frequent Yeast	Have you ever had genetic testing? ☐ Y ☐ N
☐ Acne	☐ OTHER:	If yes, please note type and results.

MEDICATIONS (Please list all prescribed medications you are taking and note reason.)

Name:	*Reason:*
Name:	*Reason:*
Name:	*Reason:*
Name:	*Reason:*
Name:	*Reason:*
Name:	*Reason:*

Have you had prolonged or regular use of NSAIDS (Advil, Aleve, etc.) Motrin, Aspirin? ☐ Y ☐ N

Have you had prolonged or regular use of Tylenol? ☐ Y ☐ N

Have you had prolonged or regular use of acid-blocking drugs (Tagamet, Zantac, etc.)? ☐ Y ☐ N

Frequent antibiotics >3 times per year? ☐ Y ☐ N Long term antibiotics? ☐ Y ☐ N

Opioid use: ☐ Y ☐ N Please specify:

Did you have any health issues as a child? ☐ Y - What age?_____ ☐ N

Describe:_____

_____

As a **child,** where there foods you avoided? ☐ Y - What age?_____ ☐ N

Explain:_____

Surgeries/Hospitalizations

Please list any surgeries or hospitalizations (include dates and your ages if known).

Lab & Diagnostic Data

Please list or upload any labs or diagnostic studies (example: CT scan, MRI, bone density, colonoscopy, etc, and provide data and age if known).

Diagnostic studies:

Family History

Please note any family history of the following diseases: *heart disease, cancer, stroke, high blood pressure, overweight, lung disease, kidney disease, diabetes, cancer, mental illness or addiction.*

Family Member:	*Health Condition:*
Family Member:	*Health Condition:*
Family Member:	*Health Condition:*
Family Member:	*Health Condition:*
Genetic Disorders Known:	

Notes:

Known genetic disorders:

Dental History

Do you have any silver/mercury amalgam fillings? ☐ Y ☐ N If **Y**, how many?

Do you have any ☐ Gold fillings ☐ Root canals ☐ Implants ☐ Bridges ☐ Crowns

Do you have any ☐ Tooth pain ☐ Bleeding gums ☐ Gingivitis ☐ Chewing problems

Do you visit a dentist regularly (twice per year)? ☐ Y ☐ N

Have you ever had an infection in your jawbone? ☐ Y ☐ N

TMJ: ☐ grinding teeth ☐ jaw clicking ☐ braces? If yes, what age ____ ☐ surgery ☐ jaw pain

Teeth: ☐ extraction? How many? _____ ☐ Which teeth are missing? (# or name)_____

Environmental Information

Do you have known adverse food reactions or sensitivities? ☐ Y ☐ N	If yes, please describe symptoms.
Are you exposed regularly to any of the following? *(check all that apply)*	What is your occupation?
☐ Cigarette smoke ☐ Auto exhaust/fumes ☐ Dry-cleaned clothes ☐ Nail polish/hair dyes ☐ Heavy metals ☐ Teflon Cookware ☐ Aluminum Cookware	☐ Perfumes ☐ Paint fumes ☐ Mold ☐ Pesticides ☐ Fertilizers ☐ Pet dander ☐ Chemicals
	Please note any regular exposure to harmful chemical/substances.
	Please not any past exposure to harmful chemicals/substances.
Do you use any recreational drugs? If so, please note.	

Do you have any pets or farm animals? __No __Yes - List: _____
If yes, where do they live? __Indoors __Outdoors __Both

Readiness Assessment

Rate on a scale of 5 (very willing) to 1 (not willing)

In order to improve your health, how willing are you to:

Significantly modify your diet	☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1
Take several nutritional supplements each day	☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1
Keep a record of everything you eat each day	☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1
Modify your lifestyle (e.g., work demands, sleep habits, exercise)	☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1
Practice a relaxation technique	☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1
Engage in regular exercise/physical activity	☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1
Have periodic lab tests to assess your progress	☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1

How much on-going support and contact (e.g., telephone, e-mail) from the nutritionist would be helpful to you as you implement your personal health program?

Lifestyle Information

Do you engage in moderate cardiovascular physical activity at least 3 days a week, for a minimum of 20 minutes duration? (brisk walking, jogging, hiking, cardio exercise classes, cycling, stair-climbing, etc.)

☐ Y ☐ N

ACTIVITY	TYPE/INTENSITY *(low-moderate-high)*	# DAYS/WEEK	DURATION *(minutes)*
Stretching/Yoga			
Cardio/Aerobics			
Strength Training			
Sports or Leisure			

Rate your level of motivation for including exercise in your life? ☐ Low ☐ Med ☐ High

Note any problems that limit your physical activity.

Do you smoke? ☐ Y ☐ N	How many years?
Packs per day?	2nd hand smoke exposure? ☐ Y ☐ N
Excess stress in your life? ☐ Y ☐ N	Easily handle stress? ☐ Y ☐ N

Daily Stressors: *Rate on a scale of 1 (low) to 10 (high)*

☐ Work____ ☐ Family____ ☐ Social____ ☐ Finances____ ☐ Health____ ☐ Other:____

Do you feel your life has meaning and purpose? ☐ Y ☐ N ☐ unsure	Do you believe stress is presently reducing the quality of your life? ☐ Y ☐ N
Average number of hours you sleep per night **during the week**?	Average number of hours you sleep per night **on weekends**?
Trouble falling asleep? ☐ Y ☐ N	Rested upon waking? ☐ Y ☐ N

Do you wake up during the night? ☐ Y ☐ N If yes, how many times?

Note the approximate times you generally wake during the night.

Do you ever need to take a sleep aid? ☐ Y ☐ N

Check off typical bedtime activities:

☐ Watch television ☐ Read a book ☐ Listen to music ☐ Bed time snack
☐ Meditate ☐ Bathe/shower ☐ Drink alcohol ☐ Drink caffeinated beverage

☐ Other-(specify)

How would you rate the overall quality of your sleep? *low quality* 1 2 3 4 5 *high quality*

How important is religion (or spirituality) to you?
☐ Not at all important ☐ Somewhat important ☐ Extremely important

Do you meditate? ☐ occasionally ☐ often ☐ never

How much control do you feel you have over your current state of health? Rate 1-10 (none-all)_____
Comment:_____

Do you get sun exposure? ☐ Y ☐ N If yes, specify ☐ Daily ☐ Weekly How much? _____

Do you wear sun block? ☐ Y ☐ N If yes, specify percentage of time_____

Social Information

What are your hobbies and leisure activities?

Describe previous jobs/work:

With whom do you live? List age of children, if any.

What is the attitude of those close to you concerning your health?
☐ Supportive ☐ Not supportive ☐ Indifferent

Are you currently married, or have you ever been married? ☐ Y ☐ N

If yes, when?	If yes, spouse's occupation:

Have you been separated or divorced? ☐ Y ☐ N - If yes, when?

Have you lived outside of the United States? ☐ Y ☐ N - If yes, when/where?

What is your total amount of airline trips, in the last year?	Estimated total in life: How many out of the country:

Have **you** experienced any major losses in your life? ☐ Y ☐ N - If yes, please comment:

Have you or your **family** recently experienced any major life changes (such as a job change)?
☐ Y ☐ N - If yes, please comment:

Have you ever had psychotherapy or counseling? ☐ Y ☐ N - If yes, please comment:

Women Only:

Number of times you have been pregnant	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
Number of miscarriages	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
Number of abortions	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
Number of premature births	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
Number of term births	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
Birth weight of largest baby: _____ Smallest baby:_____	Date of last Mammogram:_____ Normal ☐ Abnormal ☐

Did you develop toxemia? ☐ Y ☐ N

Have you had any other problems with pregnancy? ☐ Y ☐ N If yes, describe:

Age of first mensus:_____	Do you currently use contraception? ☐ Y ☐ N If yes, which type: How long?:

If you're on the pill please comment on physical or mental changes from before taking to now:

Note the approximate times you generally wake during the night:

Do you currently experience PMS (i.e. water retention, breast tenderness, irritability, etc.)?
☐ Y ☐ N If yes, specify: _____

Have you every experienced PMS in the past? ☐ Y ☐ N If yes, when?_____

Are you still menstruating? ☐ Y ☐ N : age of last period:_____

Are you experiencing menopause symptoms? ☐ Y ☐ N

Do you take: ☐ Estrogen ☐ Estrace ☐ Premarin ☐ Other-(specify)_____

Initial Symptom Survey

Date:	Patient Name:	Dietitian: Marina Bedrossian, RDN, CDN, CLT

INSTRUCTIONS: Score every symptom based on your experience **OVER THE PAST MONTH**. Using the SCALE OF SYMPTOM POINTS listed below, FILL IN the appropriate score in the corresponding field for EVERY symptom listed. Note score in the boxes to the left of symptoms. Also note the number of missed work days in the last month due to illness.

SCALE OF SYMPTOM POINTS
IF you did not suffer from the symptom ever or almost never, leave it blank.
1 = **OCCASIONALLY** (less than 2 times per week), and symptom **was MILD**
2 = **FREQUENTLY** (2 or more times per week), and symptom **was MILD**
3 = **OCCASIONALLY** (less than 2 times per week), and symptom **was SEVERE**
4 = **FREQUENTLY** (2 or more times per week), and symptom **was SEVERE**

Grand Total:	**# Missed Work Days**

	CONSTITUTIONAL
	Fatigue (sluggish, tired)
	Hyperactive (nervous energy)
	Restless (can't relax/sit still)
	Daytime sleepiness
	Insomnia at night
	Malaise (feeling lousy)
	Seizures
	TOTAL (0-28)

	EMOTIONAL/MENTAL
	Depression
	Anxiety (fears, uneasiness)
	Mood swings (rapid changes)
	Irritability
	Forgetfulness
	Lack of concentration/Brain fog
	Low sex drive
	TOTAL (0-28)

	HEAD/EARS
	Headache (not migraine)
	Migraine
	Earache
	Ear infection
	Ringing in ears
	Itchy ears
	Discharge from ears
	Sensitivity to sound
	TOTAL (0-32)

	SKIN
	Blemishes, acne
	Rashes or hives
	Eczema or psoriasis
	"Rosy" cheeks
	Flushing
	Itchy skin
	TOTAL (0-24)

	NASAL/SINUS
	Post nasal drip
	Sinus pain
	Runny nose
	Stuffy nose
	Sneezing
	TOTAL (0-20)

	MOUTH/THROAT
	Sore throat
	Swollen throat
	Swelling/burning lips/tongue
	Gagging/throat clearing
	Canker sores
	Difficulty swallowing
	TOTAL (0-24)

	LUNGS
	Wheezing
	Chest congestion
	Dry cough
	Wet cough
	Shortness of breath
	TOTAL (0-20)

	EYES
	Red or swollen eyes
	Watery eyes
	Itchy eyes
	Dark circles or "bags"
	Sensitivity to light
	Aura
	TOTAL (0-24)

	GENITOURINARY
	Increased urinary frequency
	Painful urination
	Bladder pain
	Bedwetting
	TOTAL (0-16)

	MUSCULOSKELETAL
	Joint pains
	Stiff joints
	Muscle aches
	Stiff muscles
	Ticks (facial or otherwise)
	Muscle spasms
	Muscle cramps
	TOTAL (0-28)

	CARDIOVASCULAR
	Irregular heartbeat
	High blood pressure
	TOTAL (0-8)

	DIGESTIVE
	Heartburn/reflux
	Stomach pains/cramps
	Intestinal pains/cramps
	Constipation
	Diarrhea
	Bloating sensation
	Gas (of any kind)
	Nausea
	Vomiting
	Painful elimination
	TOTAL (0-40)

WEIGHT MANAGEMENT	
Current weight:	
	Fluctuating weight
	Food cravings
	Water retention
	Binge eating or drinking
	Purging (all methods)
	TOTAL (0-20)

LIST OTHER SYMPTOMS:	

INGESTION: Nutrition History

Have you ever had a nutrition consultation? ☐ Y ☐ N

Have you made any changes in your eating habits because of your health? ☐ Y ☐ N

Please describe.

Do you currently follow a special diet or nutritional program? ☐ Y ☐ N

Check all that apply.

☐ Low fat	☐ Low Carb	☐ High protein	☐ Low sodium
☐ No Gluten	☐ Vegetarian	☐ Vegan	☐ Diabetic
☐ No Dairy	☐ No Wheat	☐ Weight Loss	☐ Other _____

How often do you weigh yourself?

Have you had any recent history of weight loss or weight gain? If so, please describe.

How many meals per day do you eat? How many snacks?

Do you avoid any particular foods? *If yes, describe.*	
If you could only eat a few foods a week, what would they be?	
How many meals do you eat out per week?	☐ 0-1 ☐ 1-3 ☐ 3-5 ☐ more than 5 per week

Check all the factors that apply to your current lifestyle and eating habits:

☐ Fast eater	☐ Family member have different tastes
☐ Erratic eating patterns	☐ Love to Eat
☐ Eating too much	☐ Eat because I have to
☐ Late night eating	☐ Have a negative relationship to food
☐ Dislike healthy food	☐ Struggle with eating issues
☐ Time constraints	☐ Emotional eater (stress, bored, etc.)
☐ Travel frequently	☐ Confused about food/nutrition
☐ Do not plan meals or menus	☐ Frequently eat fast foods
☐ Rely on convenience items	☐ Poor snack choices

Current Eating Habits

Mark the meals you eat regularly: ☐ Breakfast ☐ Lunch ☐ Dinner ☐ Snacks

Where do you obtain your food from: ☐ home prepared from whole foods ____% ☐ organic ___%

☐ home prepared convenience food ____% ☐ eat out ____%

Mark how many times you eat or drink the following items **PER WEEK**:

___ Soda (regular)
___ Soda (diet)
___ Alcohol
___ Hot tea
___ Cold tea
___ Coffee (regular)
___ Coffee (decaf.)
___ Sugar in coffee
___ Coffee drinks
___ Sweetened drinks
___ Sparkling water
___ Purified water
___ Tap water
___ Fruit juice
___ Lemonade
___ Milk (cow)
___ Milk (goat)
___ Soy Milk
___ Rice Milk
___ Nut Milk
___ Herbal teas

___ Fast food
___ Candy
___ Ice cream
___ Pudding
___ Refined sugars
___ Tuna fish
___ Swordfish
___ Sushi/sashimi
___ Salmon/other fish
___ Lunch meats
___ Bacon
___ Hot dogs
___ Whole eggs
___ Red meat
___ Poultry
___ Tofu
___ Tempeh/Miso

Sweeteners:

___ Equal/Nutrasweet (Aspartame)
___ Splenda (sucralose)
___ Saccharin
___ Stevia/Xylitol

___ Dried fruit
___ Canned fruit
___ Fresh Fruit
___ Jelly/jam
___ Sweets (cookies)
___ Green Salads
___ Raw veggies
What kind?

___ Cooked veggies
What kind?

___ Potatoes
___ Yams/Sweet Potatoes
___ Popcorn
___ Cereals
___ Oatmeal
___ Bagels/pretzels
___ White bread
___ Sprouted Br.
___ Wheat Bread

___ Crackers
___ Pasta
___ Brown rice
___ White rice
___ Corn tortillas
___ Flour tortillas
___ Potato Chips
___ Tortilla Chips
___ Pizza
___ Yogurt (plain)
___ Yogurt (sweet)
___ Prepared meals (Lean cuisine, etc.)
___ Microwave meals/soups
___ Restaurant meals (healthy)
___ Restaurant meals (unhealthy)
___ Airplane meals
___ Legumes (beans, lentils)

IF POSSIBLE: PLEASE ENCLOSE A THREE DAY FOOD RECORD (OR ONE DAY OF TYPICAL FOOD INTAKE) WITH EXACT PORTIONS. THIS IS VERY INFORMATIVE FOR YOU AND FUN TO LOOK AT. DON'T EAT "PERFECTLY" ON THESE DAYS, JUST NORMAL.

Fats and Oils

Please indicate how many times PER WEEK you eat the following fats/oils.

OMEGA 9 *(stabilizer)* ~50% of daily fat calories Oleic Fatty Acid	___ Almond Oil ___ Almonds/Cashews ___ Almond butter ___ Avocados ___ Peanuts ___ Peanut butter (natural/soft)	___ Olives ___ Olive Oil ___ Sesame Seeds/Tahini ___ Hummus (tahini oil) ___ Macadamia Nuts ___ Pine Nuts
OMEGA 6 *(controllers)* *Essential Fatty Acid Family* *~30% of daily fat calories* **LA ➔** GLA **➔** DGLA **➔** AA	___ Eggs (whole), organic (AA) ___ Meats (commercial) (AA) ___ Meats (grass-fed, org) (AA) ___ Brazil nuts (raw) ___ Pecan (raw) ___ Hazelnuts/Filberts (raw) ___ Hemp Seeds	___ Evening Primrose (GLA) ___ Black Currant Oil (GLA) ___ Borage Oil (GLA) ___ Hemp Oil ___ Grapeseed Oil ___ Sunflower Seeds (raw) ___ Pumpkin seeds (raw)
OMEGA 3 *(fluidity/communicators)* *Essential Fatty Acid Family* *~10% of daily fat calories* ALA ➔ EPA ➔ DHA	___ Fish Oil capsule: ↑DHA ___ Fish Oil capsule: ↑EPA ___ Fish (salmon/fin-fish) ___ Fish (shellfish) ___ Flax seeds/meal	___ Flax Oil ___ UDO's DHA Oil ___ Algae ___ Greens Powder w/algae ___ Chia seeds
BENEFICIAL SATURATED *(structure)* *~10% of daily fat calories* Short Chain/Medium-chain Triglycerides	___ Coconut Oil ___ Butter, organic ___ Ghee (clarified butter) ___ Dairy, raw & organic	___ Meats, grass-fed ___ Wild game ___ Poultry, organic ___ Eggs, whole organic
DAMAGED FATS/OILS (promoting stress to cells & tissues) *Should be <5% (try to avoid)* Trans Fats Acrylamides Odd-Chain Fatty Acids VLCFA/damaged	___ Margarine ___ Reg. vegetable oils (corn, sunflower, canola) ___ Mayonnaise(Commercial) ___ Hydrogenated Oil (as an ingredient) ___ "Imitation" cheeses ___ Tempura	___ Doughnuts (fried) ___ Deep-fried foods ___ Chips fried in oil ___ Reg. Salad dressing ___ Peanut Butter (JIF, etc) ___ Roasted nuts/seeds ___ Non-dairy products

INGESTION: Nutrition History (continued)

What are the top three dietary changes do you think would make the most difference in your overall health?	**1.** **2.** **3.**
How committed are you to making dietary changes in order to improve your health?	*not committed* **1 2 3 4 5** *very committed*

Please list all **nutritional supplements** you currently take daily. Please include brand names and amounts.
PLEASE BRING BOTTLES OF ALL SUPPLEMENTS AND MEDICATIONS TO FIRST VISIT

Brand:	Amount:

Do you drink alcohol? ☐ Y ☐ N If yes, how many drinks per week?

Do you drink coffee or other caffeinated beverages? ☐ Y ☐ N If yes, # daily?

Do you use artificial sweeteners? ☐ Y ☐ N If yes, which ones?

DIGESTION

Do you feel like belching or are you bloated after eating? ☐ Y ☐ N

Do you have (or had) any eating disorders? ☐ Y ☐ N If yes, please describe.

Bowel Movements: How often? _____ Color? _____ Consistency? _____

Your Birth: ☐ Natural/vaginal ☐ C-Section | Were you breastfed as an infant (if known)? ☐ Y ☐ N

Please note anything additional about your nutrition/eating habits.

ALL PATIENT INFORMATION IS HANDLED UNDER THE HIPPA PRIVACY ACT
CONFIDENTIAL / HIPPA Approved Form

Informed Consent for Nutritional Care and Lifestyle Education

I (printed name):_____Telephone:_____
Birthdate:_____ understand that Marina Bedrossian is a Registered Dietitian Nutritionist and NOT a physician. She will not diagnose or treat any medical condition, but rather, will provide nutritional support, nutrition and lifestyle education and homeopathic support for an already diagnosed condition. I will be followed concurrently for my medical condition by my physician. I understand that Marina Bedrossian's recommendations do not take the place of my physician's advice, but rather serve to augment any medical treatment I seek by optimizing the health of my body through nutrition.

I understand that by taking any dietary supplement, herbal product or homeopathic remedy that Marina Bedrossian recommends I am putting myself at risk for an allergic reaction, or for any unpredictable reaction with my medication that has not yet been found in the research literature. Marina Bedrossian does her best to research any adverse effects of any products, but sometimes there is limited research on certain products. I understand that Marina Bedrossian specifically disclaims any liability, loss or risk, personal or otherwise, that may be incurred as a consequence directly or indirectly of the use or application of any dietary or herbal supplement or homeopathic remedy. I understand that certain unpredictable side effects may result from using any dietary, herbal or homeopathic remedies, including but not limited to allergic reactions, gastrointestinal upset, nausea, vomiting, anxiety or panic attacks, or perhaps some other unknown or unrecognized adverse effect. I represent that I have disclosed to Marina Bedrossian my complete medical history including, but not limited to, any allergies or chronic medical conditions.
I understand that dietary supplements and some forms of nutritional counseling will not be reimbursed by third party payor including private health insurance and Medicare. I understand that I am personally responsible for payment to the extent Marina Bedrossian's fees are not covered by third party payors.

I hereby state that I have read this document and that any questions have been answered to my full and complete understanding and satisfaction. I therefore request nutritional counseling and recommendations regarding supplementation or dietary, herbal and homeopathic remedies from Marina Bedrossian.

Signature_____Date_____