

Erin Livers, ICNT

Nutrition Therapist

Consent for Treatment & Policy Agreement

Food As Medicine Holistic Health Counseling at the Thayer Group

1155 Alpine Avenue, Suite 230, Boulder, CO 80304
(303) 443-2010 Thayer Group (303) 499-6059 Erin's office

If your insurance company covers nutrition counseling, the Thayer Group office staff will bill your insurance company for you. If not, counseling session fees are as follows:

**Fees \$180 for initial consultation and \$180 per hour for counseling services
 \$90 per half hour**

Payments are due when services are rendered unless your insurance is being billed directly. We are happy to bill your insurance company for you. Remember to always bring your insurance card with you and plan to pay your co-payment at the time of service. We are required by the insurance companies to collect your co-pay at the time of service. (There is a ten dollar billing fee if co-pay is not paid at the time of service.)

Cash, check and all credit cards are accepted for consultations. Checks are made payable to the Thayer Group. Please make all checks for supplements payable to **Erin Livers**. Supplements are not included in the counseling session price, and prices are subject to change. In the event supplements must be mailed to you, a shipping and handling charge will be included on your invoice. Payment for these supplements must be made within 10 days of delivery.

Cancellation Policy

Scheduled appointments that are missed or not canceled with at least 24 hours notice will incur a \$50 charge. Insurance will not cover this charge. Please have the courtesy to either keep your appointment or call us with enough advance warning that we may give your time slot to someone else. If you are running late for your appointment, please call to let us know. If you are more than 30 minutes late for an appointment, we will need to reschedule your appointment.

Please sign and date below to indicate that you have been advised of these policies.

I have been advised and fully understand that as a Nutrition Therapist, Erin Livers is not a medical doctor and does not diagnose medical conditions nor prescribe controlled substances. I understand that Nutrition Therapy is not a substitute for Western Medicine and I am not seeking a medical opinion. I further understand that I am free to seek medical advice and treatment at any time.

Print name

Date

Signature

Erin Livers, ICNT

Nutrition Therapist

New Client Form

Date _____ Medical/Allergy Alerts _____

Name _____ Date of Birth _____ Age _____

Full Name given at birth _____ Cultural Heritage _____

Address _____

Email _____

Home Phone _____ Work/Cell Phone _____

Occupation _____ Employer _____

Physician/Phone _____ Date of last visit _____

Emergency Contact/Phone _____ Referred by _____

What is the reason for your visit?

List your top 5 health concerns in order of importance.

How would you describe your health?

Briefly state your relationship to the following, including any issues, concerns and/or successes.

Eating _____

Sleeping _____

Social Life _____

Creative Projects/Hobbies _____

Exercise/Activity _____

Spiritual Practices _____

Family _____

Career _____

Cooking _____

Do you cook? Yes No If no, who? _____

Do you grocery shop? Yes No If no, who? _____

Do you read food labels? Yes No How many meals do you eat out per week? _____

Do you currently follow a special diet or nutritional program? Yes No If yes:

Check all that apply:

- | | | | |
|---|-------------------------------------|---------------------------------------|--------------------------------------|
| <input type="checkbox"/> Low Fat | <input type="checkbox"/> Low Carb | <input type="checkbox"/> High Protein | <input type="checkbox"/> Low Sodium |
| <input type="checkbox"/> Diabetic/Low sugar | <input type="checkbox"/> Vegetarian | <input type="checkbox"/> Vegan | <input type="checkbox"/> Weight Loss |

Other _____

Diagnosed food allergies/sensitivities? Yes No If yes, list food(s) _____

Any foods cause indigestion/symptoms? Yes No If yes, list food(s) _____

Any foods you couldn't live without? Yes No If yes, list food(s) _____

Do you avoid any particular foods? Yes No If yes, foods/reason _____

Alcoholic drinks/week _____ Caffeinated drinks/day _____ Sodas/day _____ Diet sodas/day _____

Any immediate relatives diagnosed with Ulcerative Colitis, Crohn's Disease, Celiac Disease or IBS? Yes No

If yes, list _____

Height (feet/inches) _____ Current Weight _____ Desired Weight _____ Body Fat % _____

How often do you weigh yourself? Daily Weekly Monthly Rarely Never

Do you believe stress is presently reducing the quality of your life? Yes No

Rate your stress (1-10) during avg. week

Work _____ Family _____ Social _____ Financial _____ Health _____ Other _____

What is your preferred method(s) of relieving stress/relaxation? _____

Do you like the work you do? Yes No

Do you have trouble falling asleep? Yes No Problems w/ insomnia? Yes No Avg hrs sleep/night _____

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

- | | |
|--|---|
| <input type="checkbox"/> Fast eater | <input type="checkbox"/> You or family has special dietary needs or preferences |
| <input type="checkbox"/> Erratic eating pattern | <input type="checkbox"/> Eat more than 50% meals away from home |
| <input type="checkbox"/> Eat too much | <input type="checkbox"/> Eat only because I have to |
| <input type="checkbox"/> Late night eating | <input type="checkbox"/> Eat when sad, lonely, depressed, bored |
| <input type="checkbox"/> You or family dislikes healthy food | <input type="checkbox"/> Eat too much under stress |
| <input type="checkbox"/> Time constraints | <input type="checkbox"/> Eat too little under stress |
| <input type="checkbox"/> Love to eat | <input type="checkbox"/> Don't like to cook |
| <input type="checkbox"/> Travel frequently | <input type="checkbox"/> Eat in the middle of the night |
| <input type="checkbox"/> Do not plan meals or menus | <input type="checkbox"/> Confused about nutrition advice |
| <input type="checkbox"/> Reliance on convenience items | <input type="checkbox"/> Poor snack choices |
| <input type="checkbox"/> Smoke Amount per day _____ | |

Anything else you want me to know?

List all medications, both prescription and over-the-counter.

Medication	Dose	Frequency	Start Date (mo/year)	Reason for Use

List all nutrition supplements, vitamins, herbs, etc.

Supplement & Brand	Dose	Frequency	Start Date (mo/year)	Reason for Use

Have your medications or supplements ever caused you unusual side effects or problems? Yes No

Prolonged or regular use of NSAIDS (Advil, Aleve, Motrin, Aspirin)? Yes No

Prolonged or regular use of Acid Blocking Drugs (Tagamet, Zantac, Prilosec, etc.) Yes No

Frequent antibiotics (>3x/year)? Yes No Long term antibiotics? Yes No

Use of steroids prednisone, nasal allergy inhalers) in the past? Yes No

List hospitalizations, include dental surgeries and serious injuries/broken bones.

Date	Reason

Health History

Blood type: A B O AB Rh negative

Check any conditions you have or have had in the past.

- | | | | | |
|--|--|---|--|--|
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Headaches | <input type="checkbox"/> Mental condition | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Seasonal allergies | <input type="checkbox"/> Asthma | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Parasites/Giardia | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Urinary Tract Infections | <input type="checkbox"/> Interstitial Cystitis | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> Eating disorder | <input type="checkbox"/> Hiatal Hernia | <input type="checkbox"/> Eczema | <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Gall Stones |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Gout | <input type="checkbox"/> Kidney Infect/Stone | <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Drug Addiction |
| <input type="checkbox"/> Hypo/Hyperthyroid | <input type="checkbox"/> Frequent Colds/Flu | <input type="checkbox"/> Macular Degeneration | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Candidiasis (Yeast) |
| <input type="checkbox"/> IBS/IBD | <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> Weight Loss or Gain | <input type="checkbox"/> GERD | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Diabetes Type I or II | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Celiac |
| <input type="checkbox"/> Any AutoImmune Condition_____ | | | | |
| <input type="checkbox"/> Cancer_____ | | | | |

Dental Problems: Mercury Amalgams Root Canals #_____ Bleeding Gums Gum Disease

Patient Birth History

Term Premature? Any pregnancy/birth complications?_____

Breast Fed Bottle Fed How long?_____

Did you eat a lot of candy or sugar as a child? Yes No

Menstrual History (women only)

Age at first period_____ Menses Frequency_____ Length_____ Pain? Yes No Clotting? Yes No

Ever skipped your period? Yes No For how long?_____

Check all that apply. PMS Heavy Periods PCOS Abnormal PAP

Fibrocystic breasts Endometriosis Facial hair growth Fibroids Infertility

Increased libido Decreased libido (sex drive)

Hormonal contraceptives? Yes No For how long?_____ Type?_____

Pregnancies_____ Number of living children_____

Date of last PAP/result_____

Are you in menopause? Yes No Age at menopause_____ Years in menopause_____

Check all that apply. Hot flashes Mood swings Weight Gain Incontinence

Concentration/Memory Problems Vaginal Dryness Decreased libido Depression

Use of hormone therapy. Yes No How long?_____

Date of last Mammogram/result_____

Men's History (men only)

Live alone Live with family Live with spouse/partner

Have you had a PSA test? Yes No PSA Level: 0-2 2-4 4-10 >10

Check all that apply. Muscle Soreness Mood swings Weight Gain esp waist/hips Mental fatigue

More emotional than in the past Depression Decreased physical stamina Decreased libido

Decrease in spontaneous erections Decrease in fullness of erections Sweating attacks

Urination difficulty or dribbling Frequent Urination Leg nervousness at night

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Physical Systems Assessment Form

Name _____ Date _____

Please circle the appropriate number (0-3) on all questions below. 0=least/never, 3=most/always.

Category 1

Excessive belching, burping or bloating 0 1 2 3
 Gas immediately following meal 0 1 2 3
 Offensive breath 0 1 2 3
 Difficult bowel movements 0 1 2 3
 Sense of fullness during and after meals 0 1 2 3
 Undigested foods found in stools 0 1 2 3

Category 2

Stomach pain, burn or ache 1-4 hrs after eating 0 1 2 3
 Use antacid (Nexium, Priolosec, +) for heartburn 0 1 2 3
 Feel hungry 1-2 hours after eating 0 1 2 3
 Heartburn - lying down or bending forward 0 1 2 3
 Temp relief - antacids, food, milk or carb bevs 0 1 2 3
 digestive problems subside with rest/relaxation 0 1 2 3
 Heartburn due to spicy foods, chocolate, citrus, 0 1 2 3
 peppers, alcohol and/or caffeine

Category 3

Feeling that bowels do not empty completely 0 1 2 3
 Low abdominal pain relief by passing stool/gas 0 1 2 3
 alternating constipation and diarrhea 0 1 2 3
 diarrhea 0 1 2 3
 Constipation 0 1 2 3
 Hard, dry or small stool 0 1 2 3
 Coated tongue (tongue feels "fuzzy") 0 1 2 3
 Pass large amount of foul-smelling gas 0 1 2 3
 More than 3 bowel movements daily 0 1 2 3
 Use laxatives 0 1 2 3

Category 4

Greasy or high fat foods cause distress 0 1 2 3
 Gas and/or bloating 2-4 hrs after eating 0 1 2 3
 Bitter metallic taste, esp in morning 0 1 2 3
 Unexplained itchy skin 0 1 2 3
 Yellowish cast to whites of eyes 0 1 2 3
 Reddened skin, esp. palms 0 1 2 3
 Dry or flaky skin and/or hair 0 1 2 3
 History of gallbladder attacks or stones 0 1 2 3
 Have you had your gall bladder removed? Yes No

Category 5

Dark under eye circles 0 1 2 3
 Digestive symptoms after eating 0 1 2 3
 Messy/sticky bowel movements 0 1 2 3
 Stiff neck, jaw tension and/or headaches 0 1 2 3
 Joint pain 0 1 2 3
 Heartburn 0 1 2 3
 Eczema 0 1 2 3
 Hives 0 1 2 3

Category 6

Crave sweets during the day 0 1 2 3
 Irritable if meals are missed 0 1 2 3
 Depend on coffee to keep going or get started 0 1 2 3
 Get lightheaded if meals are missed 0 1 2 3
 Eating relieves fatigue 0 1 2 3
 Feel shaky, jittery 0 1 2 3
 Agitated, easily upset, nervous 0 1 2 3
 Poor memory, forgetful 0 1 2 3
 Blurred vision 0 1 2 3

Category 7

Fatigue after meals 0 1 2 3
 Crave sweets during the day 0 1 2 3
 Eating sweets does not relieve cravings for sugar 0 1 2 3
 Must have sweets after meals 0 1 2 3
 Waist size is equal or larger than hip size 0 1 2 3
 Frequent urination 0 1 2 3
 Increased thirst and appetite 0 1 2 3
 Difficulty losing weight 0 1 2 3
 Binge eating 0 1 2 3
 Crave specific foods 0 1 2 3

Category 8

Cannot stay asleep 0 1 2 3
 Crave salt 0 1 2 3
 Slow starter in the morning 0 1 2 3
 Afternoon fatigue 0 1 2 3
 Dizziness when standing up quickly 0 1 2 3
 Afternoon headaches 0 1 2 3
 Headaches upon exertion or stress 0 1 2 3
 weak nails 0 1 2 3
 Dark under eye circles 0 1 2 3

Category 9

Cannot fall asleep 0 1 2 3
 Perspire easily 0 1 2 3
 Under high amounts of stress 0 1 2 3
 Weight gain when under stress 0 1 2 3
 Wake up tired even after 6 or more hrs of sleep 0 1 2 3
 Excess perspiration w/ little/no activity 0 1 2 3

Category 10

Tired, sluggish 0 1 2 3
 Fell cold - hands, feet, all over 0 1 2 3
 Require excessive sleep to function properly 0 1 2 3
 Gain weight easily even with low-cal diet 0 1 2 3
 Difficult, infrequent bowel movements 0 1 2 3
 Depression, lack of motivation 0 1 2 3
 Morning headaches that wear off through day 0 1 2 3
 Outer third of eyebrows thin 0 1 2 3
 Thinning hair or excess hair loss 0 1 2 3
 Mental sluggishness 0 1 2 3
 Extremely dry skin/scalp 0 1 2 3

Category 11

Heart palpitations 0 1 2 3
 Inward trembling 0 1 2 3
 Increased pulse even at rest 0 1 2 3
 Nervous and emotional 0 1 2 3
 Insomnia 0 1 2 3
 Night sweats 0 1 2 3
 Difficulty gaining weight 0 1 2 3

Category 12

Extreme fatigue 0 1 2 3
 Mental fogginess 0 1 2 3
 Joint aches and pains 0 1 2 3
 Vaginal yeast infections (> 2/yr) 0 1 2 3
 Mood swings 0 1 2 3
 Depression 0 1 2 3
 Clogged sinuses 0 1 2 3

Category 12 cont'd

Gas/bloating immediately after eating sugar	0	1	2	3
Constipation	0	1	2	3
Diarrhea	0	1	2	3
Rectal itching	0	1	2	3
Athlete's foot or jock itch	0	1	2	3
Dandruff	0	1	2	3

Category 13

Latex allergy	0	1	2	3
Sensitive - perfume, exhaust, smoke, odors	0	1	2	3
Frequent colds/flu	0	1	2	3
Seasonal or pet allergies	0	1	2	3
Do you have pets?	Yes	No		
Do your pets live	<input type="checkbox"/> Indoors	<input type="checkbox"/> Outdoors	<input type="checkbox"/> Both	
Symptoms worsen in damp/moldy environments	0	1	2	3

Category 14

Muscle cramps or spasms	0	1	2	3
Difficulty concentrating	0	1	2	3
Irritability	0	1	2	3
Loss of appetite	0	1	2	3
Heart palpitations	0	1	2	3
High blood pressure	0	1	2	3
Diarrhea	0	1	2	3
Drink 2 or more alcohol drinks, 4+ days/week	0	1	2	3
History of kidney stones	0	1	2	3

Category 15

Chest congestion	0	1	2	3
Asthma, bronchitis	0	1	2	3
Frequent sinus infections	0	1	2	3
Sinus congestion	0	1	2	3

Neurotransmitter Assessment Form

Please circle the appropriate number (0-3) on all questions below. 0=least/never, 3=most/always.

Section A

Noticeable memory decline	0	1	2	3
Difficulty remembering names/phone numbers	0	1	2	3
Noticeable ability to focus decline	0	1	2	3
More difficult to learn new things	0	1	2	3
Temperament worsening	0	1	2	3
Losing attention span endurance	0	1	2	3
Fatigue sooner when driving than in the past	0	1	2	3
Fatigue sooner when reading than in the past	0	1	2	3
Walk into rooms and can't remember why	0	1	2	3
Pick up phone and can't remember why	0	1	2	3

Section B

Stress level high	0	1	2	3
Always something that must be done	0	1	2	3
Never time for self	0	1	2	3
Not getting enough sleep or rest	0	1	2	3
Not enough time for exercise	0	1	2	3
Feel unsupported by people around you	0	1	2	3
Not accomplishing your life purpose	0	1	2	3
No one to share daily problems with	0	1	2	3

Section C

Losing your pleasure in hobbies and interests	0	1	2	3
Feel overwhelmed with ideas to manage	0	1	2	3
Feelings of inner rage or anger	0	1	2	3
Feelings of paranoia	0	1	2	3
Feel sad or down for no reason	0	1	2	3
In general, feel like you're not enjoying life	0	1	2	3
Lack of artistic appreciation	0	1	2	3
Depressed in overcast weather	0	1	2	3
Losing enthusiasm for favorite activities	0	1	2	3
Losing enjoyment for favorite foods	0	1	2	3
Losing enjoyment for friendships/relationships	0	1	2	3
Difficulty falling into deep, restful sleep	0	1	2	3
Feelings of dependency on others	0	1	2	3
More susceptible to pain	0	1	2	3
Feelings of unprovoked anger	0	1	2	3
Losing interest in life	0	1	2	3

Section D

Feelings of hopelessness	0	1	2	3
Self-destructive thoughts	0	1	2	3
Inability to handle stress	0	1	2	3
Anger/aggression while under stress	0	1	2	3
Don't feel rested even after adequate/long sleep	0	1	2	3
Prefer isolation from others	0	1	2	3
Unexplained lack of concern for family/friends	0	1	2	3
Easily distracted	0	1	2	3
Inability to finish tasks	0	1	2	3
Need caffeine to stay alert	0	1	2	3
Decreased libido (sex drive)	0	1	2	3
Lose temper for minor reasons	0	1	2	3
Feelings of worthlessness	0	1	2	3

Section G

Feel anxious or panic for no reason	0	1	2	3
Feelings of dread or impending doom	0	1	2	3
Knots in stomach	0	1	2	3
Unreasonable feelings of overwhelm	0	1	2	3
Feel guilty about everyday decisions	0	1	2	3
Restless mind	0	1	2	3
Difficult to turn mind off to relax/sleep	0	1	2	3
Disorganized attention	0	1	2	3
Worry about things never worried about before	0	1	2	3
Feelings of inner tension/inner excitability	0	1	2	3

Section C

Visual memory (shapes/images) decreased	0	1	2	3
Verbal memory decreased	0	1	2	3
Memory lapses	0	1	2	3
Decreased creativity	0	1	2	3
Mental comprehension diminished	0	1	2	3
Difficulty calculating numbers	0	1	2	3
Difficulty recognizing objects/faces	0	1	2	3
Your opinion of yourself has changed	0	1	2	3
Excessive urination	0	1	2	3
Slower mental response	0	1	2	3
Noticeable ability to focus decline	0	1	2	3