The Morrison Center

461 Park Avenue South, 12th Floor
New York, NY 10016
212-989-9828 (O) / 212-989-9827 (F)
www.MorrisonHealth.com

NOTICE OF PRIVACY PRACTICES

We are required by applicable and federal law to maintain the privacy of your health information. Whether the law requires it or not, it has always been our policy to strictly protect the confidentiality of the protected health information of all of our patients, and we release medical information regarding a patient only whenever the patient instructs us to do so, or when we are required to do so by law.

OUR LEGAL DUTY

However, because we do not transmit your protected health information via electronic means in connection with certain transactions enumerated in the Health Insurance Portability and Accountability Act, commonly known as HIPAA, we are not required to give you Notice about our privacy practices, unlike some of your other providers who may have treated you in the past. We choose to do so, nevertheless, out of our respect for you as our patient, and because we want you to be aware of some situations in which your information may be disclosed or shared with others, and under what circumstances.

We reserve the right to change our privacy practices and terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information above.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

TREATMENT: We may use or disclose your health information to a physician or other healthcare provider who is providing treatment to you.

PAYMENT: We may use and disclose your health information to obtain payment for services we provide to you.

HEALTHCARE OPERATION: We may use and disclose your health information for treatment in connection with our healthcare operations. Healthcare operations includes quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

YOUR AUTHORIZATION: In addition to our use of your health information for treatment, payments or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose.
If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

TO YOUR FAMILY AND FRIENDS: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

PERSONS INVOLVED IN YOUR CARE: We may use or disclose health information to notify or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-ray, or other similar forms of health information.

MARKETING HEALTH-RELATED SERVICES: We will not use your health information for marketing communications without your written authorization.

REQUIRED BY LAW: We may use or disclose your health information when we are required to do so by law.

ABUSE OR NEGLET: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety others.

NATIONAL SECURITY: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counter-intelligence, other national securities activities. We may disclose to correctional institution or lawful inmate or patient under certain circumstances.

APPOINTMENT REMINDERS: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards or letters).

PATIENTS RIGHTS

ACCESS: You have the right to look at copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies.
We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $25 for staff time to locate and copy your health information, and postage if you want it mailed to you.

DISCLOSURE ACCOUNTING: You have the right to receive a list of instances in which our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

RESTRICTION: You have the right to request that we place additional restrictions on our use or disclosure of health information. We are not required to agree to these additional restrictions, but we if we do, we will abide by our agreement (except in an emergency).

ALTERNATIVE COMMUNICATION: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the means or location you request.

AMENDMENT: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

ELECTRONIC NOTICE: If you receive this Notice on our web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

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Patient Registration Form

Last Name	**First Name**	**M.I.**
Address		
City	**State**	**Zip**
Cell #	**Work #**	**Home#**
Birth Date	**SS #**	**Gender** ◯ **Male** ◯ **Female**
Insurance Company	**Policy#**	
Physician Name	**Physician Phone #**	
Employed by	**Occupation**	
Emergency contact name	**Emergency contact #**	
How did you hear about The Morrison Center?		
What is the main reason of your visit?		
Pharmacy name, address and phone (*REQUIRED*)		

Email address: _____ Date:_____

Join hundreds of Morrison Center community members on our exclusive email list. You'll receive health tips, recipes and more to help you achieve your health goals. Check here to sign up ◯

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New Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment or Healthcare Operations

SECTION A: PATIENT GIVING CONSENT
Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the disclosures we may make of your protected health information, and of other important matters about your protected health information.
A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain. You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting in writing: **The Morrison Center, 461 Park Avenue South, 12th Fl. New York, NY 10016**

Right to Revoke: You have the right to revoke this Consent at any time by giving us a written notice of your revocation submitted to the address listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent

Patient Name (please print): _____

SIGNATURES: I, _____, have had full opportunity to read and consider the contents of this Consent form and Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative Name: _____

Relationship to Patient: _____

YOU ARE ENTITILED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
REVOCATION OF CONSENT
I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations. I understand that revocation of my Consent will not affect any action you took in reliance on my consent before you receive this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I revoke my Consent.

Signature: _____ Date: _____

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Medical History Form

Please complete 3 pages

NAME: _____ **DATE:** _____

AGE: _____ How would you rate your health? ◯ Excellent ◯ Good ◯ Fair ◯ Poor

PRESENT HEALTH CONCERNS: _____

PERSONAL MEDICAL HISTORY:

Please indicate whether you have had any of the following medical problems (with dates):

_____Heart Disease
_____Alcoholism *Specify Type* _____
_____Heart Attack
_____Cancer (Malignancy) _____
_____Blood Transfusion
_____Diabetes Specify type _____
_____Thyroid Problems
_____Bleeding/Clotting problem
_____High Cholesterol
_____High Blood Pressure
_____Depression/Suicide Attempt
_____Stroke

Other Problems (specify):_____

SURGICAL HISTORY:

Please list all prior operations (with dates): _____
_____

MEDICATIONS:

Prescription and non prescription medicines, vitamins, home remedies, birth control pills, herbs:

Medication	Dose (eg.mg/pill)	How many times per day	When started

ALLERGIES or REACTIONS TO MEDICINES: _____

Please place a check next to your **IMMUNIZATIONS:**

Hepatitis A ☐ Hepatitis B ☐ Influenza ☐ Measles ☐
Pneumovax(Pneumonia) ☐ Rubella ☐ Tetanus(Td) ☐ Varicella (Chicken Pox) ☐

When were your most recent **HEALTH MAINTENANCE** screening tests:

Cholesterol Screening:_____ Results?_____ Prostate Cancer screen:_____ Results?_____
Sigmoidoscopy:_____ Results?_____ Stool test for Blood:_____ Results?_____
Mammogram:_____ Results?_____ Pap Smear:_____ Results?_____
-Ever Abnormal:_____ Details:_____ -Ever Abnormal:_____ Details: _____

FAMILY HISTORY

Please indicate the current status of your immediate family members:

	Alive	Deceased	Age (now or at death)	Cause of death
Mother				
Father				
Sister #				
Brother #				
Daughter #				
Son #				

Please check family members who have had any of the following conditions:

Medical condition	Mom	Dad	Sist.	Bro.	Daug.	Son
Alcoholism						
Anemia						
Arthritis						
Asthma						
Autoimmune Disorder						
Birth Defects						
Bleeding Problem						
Cancer, Breast						
Cancer, Colon						
Cancer, Melanoma						
Cancer, Ovary						
Cancer, Prostate						
Depression						
Diabetes, Type 1 (Childhood onset)						
Diabetes, Type 2 (Adult onset)						
Eczema						
Food Allergies						
Hay Fever						
Hearing Problems						
Heart Attack (Coronary Artery Disease)						
High Cholesterol						
High Blood Pressure						
Kidney Diseases						
Osteoporosis						
Epilepsy (Seizure Disorder)						
Stroke						
Substance Abuse						
Smoking						
Thyroid Disorders						
Other:						

SOCIAL HISTORY

Substance & Sexuality

Tobacco Use

Cigarettes ☐ Never ☐ Quit: Date_____

Pipe ☐ Cigar ☐ Snuff ☐ Chew ☐

Current Smoker: packs/day _____ #of years_____

Are you interested in quitting? ◯ No ◯ Yes

Alcohol Use

Do you drink alcohol? ◯ No ◯ Yes #drinks/week___

Is alcohol use a concern for you or others? ◯ No ◯ Yes

Drug Use

Do you use any recreational drugs? ◯ No ◯ Yes

Have you ever used needles? ◯ No ◯ Yes

Sexual Activity

Sexually Active: ◯ No ◯ Yes ◯ Not currently

Current sex partner(s)is/are ◯ Male ◯ Female

Birth control method: _____ None needed ☐

Have you ever had any sexually transmitted diseases (STDs)? ◯ No ◯ Yes _____

Are you interested in being screened for sexually transmitted diseases? ◯ No ◯ Yes

Other Concerns:

Caffeine Intake: _____None Coffee/ Tea: _____cups/day

Sodas: _____/day Chocolate: _____oz/day

Weight: Are you satisfied with your weight? ◯ No ◯ Yes

Diet: How do your rate your diet? ◯ Good ◯ Fair ◯ Poor

Do you take supplement? ◯ No ◯ Yes

(List on supplement sheet)

Exercise: Do you exercise regularly? ◯ No ◯ Yes

What kind of exercise?_____

How long? (minutes)_____ How often? _____

If you do not exercise, why?_____

Is violence at home a concern for you? ◯ No ◯ Yes

Have you ever been abused? ◯ No ◯ Yes

SOCIOECONOMICS

Occupation:_____ Employer: _____

Years of Education / Highest Degree _____ Marital Status: ◯ S ◯ M ◯ D ◯ W ◯ Other____

Spouse / Partner's Name: _____ Number of children/ ages: _____

Who lives at home with you? _____

SPECIALTY HISTORY:

For women: #Pregnancies:____ #Deliveries:____ #Abortions:____#Miscarriages:____

1st day, most recent period: _____ Age at 1st period: _____ Frequency periods:_____ Length of each:_____

Do you have any concerns about your periods? ◯ No ◯ Yes _____

Do you have any concerns about menopause? ◯ No ◯ Yes _____

REVIEW OF SYMPTOMS:

please check (X) any current problems you have on the list below:

Constitutional
- ☐ Fevers/chills/sweats
- ☐ Unexplained weight loss/gain
- ☐ Change in energy/ weakness
- ☐ Excessive thirst or urination

Eyes
- ☐ Change in vision

Ears/Nose/Throat/Mouth
- ☐ Difficult hearing/ringing in ears
- ☐ Problems with teeth/gums
- ☐ Hay fever/Allergies

Cardiovascular
- ☐ Chest pain/discomfort
- ☐ Palpitations

Chest
- ☐ Breast lump/nipple discharge

Respiratory
- ☐ Cough/wheeze
- ☐ Difficulty breathing

Gastrointestinal
- ☐ Abdominal pain
- ☐ Blood in bowel movement
- ☐ Nausea/vomiting/diarrhea

Genitourinary
- ☐ Nighttime urination
- ☐ Leaking urine
- ☐ Unusual vaginal bleeding
- ☐ Discharge: penis or vagina

Musculo-skeletal
- ☐ Muscle/ joint pain

Skin
- ☐ Rash/mole change

Neurological
- ☐ Headaches
- ☐ Dizziness/light headedness
- ☐ Numbness
- ☐ Memory loss
- ☐ Loss of coordination

Psychiatric
- ☐ Anxiety/Stress
- ☐ Problem with sleep
- ☐ Depression

Blood/Lymphatic
- ☐ Unexplained lumps
- ☐ Easy bruising/bleeding

Other
- ☐ Problems with sexual function

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INFORMED CONSENT FORM

I seek the medical and health care services of Jeffrey A. Morrison, M.D., his employees and staff. I understand that this medical practice uses some diagnostic and treatment methods that are variously known as environmental, complementary, alternative, and integrative holistic, or nutritionally oriented. Some of the methods have not been accepted by conventional medical practitioners conforming to common standards of practice in the United States. Some of the characteristic qualities of environmental medicine that are used in this practice include the following:

1. **Life Style –** A person's life-style, including his or her diet, exercise pattern, sleep habits, stresses and interpersonal relationships, is believed to be directly related to the development and maintenance of illness. Integrative medicine evaluates these factors and seeks to help the patient give up negative life style patterns and establish more positive ones regardless of age or type of medical problem.

2. **Nutritional supplements –** Although prescription and over the counter medications are used when the physician believes it is necessary, an attempt is first made to use products that are natural to the body. These include nutritional supplements such as vitamin, mineral, enzymes, amino acids, essential fatty acids and herbs.

3. **IV Therapy –** In addition to recommending that a patient take nutritional supplements by mouth, we frequently recommend that a patient receive a series of injections either intravenously or by intramuscular injection. Some of the reasons for recommending this procedure include the assurance that the particular substance gets into the body (which may not happen when the supplement is taken orally and the patient has absorption problems) and achieving high concentration of the substance in the bloodstream, which may be difficult if the substance is taken by mouth.

4. **Diagnostic Tests –** Because we look for imbalances in the body and for trends that may result in illness if not addressed, we sometimes order tests that may be considered by consensus mainstream medicine to be unnecessary or of no value. These tests may include tests for nutritional status, such as blood levels, or functional vitamin or mineral tests, hormone level urine test or tests for allergies. For example, we frequently recommend testing via the method provocation/ neutralization, a method used by many environmental physicians who are members of the American Academy of Environmental Medicine (AAEM). This test involves a series of injections or under the tongue challenges with substances suspected of causing allergic reactions or intolerance.

5. **Detoxification –** We believe that environmental factors may play a major role in health and disease. Some of the diseases of unknown causes may be triggered or perpetuated by common environmental substances, many of which are man-made. Individuals may vary greatly in their susceptibility to various substances, while another is not affected. We attempt to identify offending substances and help patients detoxify from past exposures that are affecting them.

Initial _____

6. **Patient participation –** We very much believe in a person being involved in their own health care and encourage questions and participation in decisions surrounding diagnosis and treatment procedures. We encourage consultations with consensus mainstream medicine practitioners and the use of any other means that a person feels is needed to help decide about their health issues. We would like you to bring your medical records from your other practitioners, as it is important that the care you are receiving from multiple practitioners is compatible. Please continue on the medications prescribed by your other physicians and be sure to inform our physician of the medications you may be taking.

7. **Mind-Body-Spirit -** We believe in the mind-body-spirit connection in bringing about wellness and preventing illness. Consequently, part of our program may involve recommendations for counseling, meditation or psychotherapy.

8. **Exercise –** Exercise is extremely important in maintaining health and promoting wellness as well as helping one to recover from an illness. Graded exercise, both aerobic and stretching, is encouraged for most patients.

The above represents some of the ways that this practice may differ from other physician's offices that you have visited. You should also be aware of the following points:

1. **Office-based Practice -** Our practice is an office-based consultation practice. **We do not work in a hospital.** Additionally, some patients come long distances to receive care at our office. Consequently, we require, that in addition to our care, you maintain a relationship with your primary care provider and *I* or one or more physicians appropriate to your condition and situation. For example, you may want to have a relationship with a family physician or a pediatrician in the care of your child. Cardiac patients should have either a cardiologist or an internist or both. We are happy to work with any physician that you are working with.

2. **WE MAKE NO REPRESENTATIONS, CLAIMS OR GUARANTEES THAT YOU WILL BE HELPED WITH YOUR MEDICAL PROBLEMS OR CONDITIONS BY UNDERGOING TREATMENT HERE.** However, we will do our best to help you accomplish your healthcare and wellness goals.

3. **Sale of Supplements** – In the office, we make available nutritional supplements and other recommended products. You are in no way obligated to purchase these products from this office. You are free to purchase these products from any source that you may choose. The products sold at this office are sold on a for profit basis.

4. **Health Insurance** - Most health insurance plans today have clauses that limit coverage to "usual and customary services". Because many of the treatments used in integrative medicine are not recognized by consensus mainstream medicine, we cannot guarantee the amount or availability of coverage for our services and treatments under your health insurance policy. **You are responsible for your payment of our invoice at the time of service, without regard to insurance coverage**. You are entitled to know the cost of all services and procedures in advance. Please ask if they are not told to you.

Initial _____

I have read, understand and agree to the foregoing. I agree that if I have any claim with respect to the services and treatment given to me by Jeffrey A. Morrison, M.D., his employees and/or staff that they shall be judged by the standards and principles of environmental, complementary, alternative, integrative and holistic medicine. I understand that I have the right to review this consent with a lawyer if I choose. I have executed this consent

freely and willingly and understand its provisions. I recognize that Jeffrey A. Morrison, M.D. will rely upon execution of this document in accepting me as a patient. I acknowledge receipt of a copy of this consent.

_____ _____

Print Name Date

_____

Signature

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Cancellation Policy

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment schedule.

If an appointment is not cancelled with at least 24 hours notice in advance you will be charged a $300.00 fee.

We thank you for your understanding.

Please sign and date below to indicate that you have read and understand the above policy.

_____ _____

Print Name Date

_____

Signature

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Prescriptions and Test Results Policy

PRESCRIPTION REFILLS POLICY

ROUTINE PRESCRIPTIONS: When we write prescriptions we will provide enough refills to last until your follow-up visit. **Therefore, if you are running out of medication and refills, you are probably due for a return visit.** In situations when you have been to the office recently for other issues, we may be able to refill your prescription without another visit. Please have your pharmacy fax a refill request to 212-989-9827. Please give us 48 hours to review and confirm the refill with your pharmacy. If you are unable to wait 48 hours, please schedule a same- or next-day appointment. If you have not been to the office in at least six months, you will likely need a follow up visit before receiving any refills in order for us to monitor your dose.

NEW PRESCRIPTIONS: Under no circumstance will we prescribe over the phone. A prescription for a new condition or one written by another physician requires an office visit.

CONTROLLED SUBSTANCES: All controlled substance refills (tranquilizers, hypnotics, analgesics and stimulants) **require an office visit.** If you run out of medication and cannot make it into the office, we can only call in a five day emergency supply to your pharmacy, however you must follow-up before the next refill.

TEST RESULTS POLICY

Our policy is to consistently provide feedback to patients about test results for every test we order. **We do this by having you set up an appointment at the time of your blood draw**. Results can take anywhere from 7 to 30 days to be received by our office. If you do not hear from us within 15 business days for MOST labs, please give us a call to make sure we have received your results.

NORMAL & ABNORMAL RESULTS: Please schedule an appointment to review your results after your blood draw. A visit allows us to spend time reviewing your chart and lab results, getting additional history and answering your questions.

_____
PATIENT NAME

_____
PATIENT SIGNATURE

_____
DATE

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Acknowledgment Regarding Reimbursement By Medical Insurance Carrier

By signing below, I hereby acknowledge that I have been fully advised that some or all of the costs associated with my visit(s) to The Morrison Center ordered on my behalf and with my consent or at my request may not be eligible for insurance reimbursement in accordance with the terms and provisions of my particular medical insurance policy(s) and that such diagnostic test and/or procedures may be or already have been determined to be "non-covered services" by my particular medical insurance carrier(s).

Due to the fact that the terms and provisions of medical insurance policies may differ, The Morrison Center has informed me that medical insurance carriers do not always agree with the medical necessity, clinical value, reasonableness or essentiality of every diagnostic test and/or procedure that may be ordered.

Based upon the foregoing, I have been provided with an opportunity to ascertain the eligibility for insurance reimbursement of all diagnostic tests and/or procedures ordered and with a further opportunity to discuss any questions in connection therewith prior to undergoing the same. I have also been provided with an opportunity to defer undergoing such diagnostic tests and/or procedures as a result of my inability to obtain insurance reimbursement.

The Morrison Center has made any representation to me whatsoever with respect to the eligibility for insurance reimbursement of any given diagnostic test and/or procedure that may be ordered.

I am signing this acknowledgment voluntarily and of my own free will and volition. I fully understand the contents of this acknowledgement and the financial ramifications inherent therein.

I understand and agree that (regardless of my insurance status) I am responsible for the balance of my account for any professional services rendered. I have read all of the information on this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information.

_____ _____

Print Name Date

_____

Signature

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DIET AND NUTRITION QUESTIONNAIRE

Patient Name: _____ Date: _____

1. Please list every supplement you currently take.

NAME	TYPE	BRAND	STRENGTH	FREQUENCY
i.e. Vitamin E	*Mixed tocopherol*	*Solar*	*400 I.U.*	*1 per day*

2. Which oils do you consume?

- ☐ Butter
- ☐ Margarine
- ☐ Sunflower
- ☐ Crisco
- ☐ Vegetable oil
- ☐ Peanut oil
- ☐ Grapeseed oil
- ☐ Safflower oil
- ☐ Coconut oil
- ☐ Flaxseed oil
- ☐ Canola oil
- ☐ Olive oil
- ☐ Corn oil
- ☐ Mayonnaise
- ☐ Soybean oil
- ☐ Other _____

3. Where do you eat most of your meals, at home or away from home?

_____

4. Have you tried a dietary weight loss program(s)? Which one(s)? What were the results?

_____

5. Are there any particular foods that cause you problems? If so, what foods and what are your experiences?

_____

6. Do you have cravings for any specific foods? If so which ones?

_____

7. How much water do you drink daily? _____ (number of glasses or ounce)

8. Please list foods and beverages you would eat during a typical day:

BREAKFAST	LUNCH	DINNER	SNACKS

9. Do you notice any change in mood or energy associated with the consumption of sugar or high carbohydrate foods?

_____

10. Do you prefer low fat/complex carbohydrate meals or low carbohydrate/high protein meal?

_____

11. Have you been tested for food allergies? If so what was the test? What were the results?

_____

12. Have you ever tried an elimination diet? If so, what did you eliminate, and what were the results?

_____

13. Do you have any ethical or religious restrictions on your diet e.g. Kosher or ethical vegetarian?

_____

_____ _____

Print Name Date

_____

Signature