

Nutrition and Wellness Counseling

NHL Ministries beth m. leyd, ph.d.

Call 763-391-7636 / 763-614-8842 or email bley@blpublications.com
for more information or to set up an appointment

Appointments available: In Person, E-mail or by Phone. Call for fees.

For e-mail or phone consults: Please mail completed questionnaire and payment to

NHL Ministries 649 Kayla Lane, Hanover, MN 55341

(MC and VISA accepted) Checks made payable to NHL Ministries

Nutritional wellness and Christian counseling includes dietary and supplemental recommendations which you may or may not choose to implement. As a nutrition counselor, I do not and cannot offer medical advice, diagnosis, or prescribe any cures. The nutritional information provided will be based on the information you provide, scientific facts as published in peer-reviewed journals and discernment, not on fads or marketing schemes. All information will be kept confidential. Please sign here after you have read and understand the information in this box:

_____ date: _____

This questionnaire is designed to assist in the proper evaluation of your personal history and current nutritional status to make the appropriate recommendations. Please fill this out completely and bring it with you at your appointment (or mail and indicate email counseling preferred and include check or credit card info, number and exp. date).

Name _____ Phone number _____

Mailing address _____ Email: _____

City, state, zip _____

Date of birth _____ Height _____ Weight _____ Desired weight _____ Male or Female (Circle one)

Contact in case of emergency _____ ph _____

Do we have your permission to share pertinent information about your health situation with this person? _____

(Note: you may want to include this person in your counseling visits)

What is your ethnic background? German? Native American? etc. _____

What is your blood type (if known) _____ Do you check your urine pH? _____ If so, what are results? _____

When was your last physical or check up? _____

What was the summary or recommendation(s)? _____

Please list any surgery you have had and the approx. year: _____

Do you have a/any specific health problem (s) you are concerned about? _____ If so, please list:

Are you taking any medications? _____ If so, please list (include dosages):

Do you smoke or use chewing tobacco? _____ of have any other "habits" that may be detrimental to your health? _____

Are you taking any nutritional supplements? _____ If so, please list (include dosages):

3-DAY FOOD DIARY:

Please list all the foods and beverages (and approx. amounts) you have consumed in the last 3 days

Day 1: AM

Comments or Suggestions:

Day 2: Lunch

Day 1: PM

Day 2: AM

Day 2: Lunch

Day 2: PM

Day 3: AM

Day 2: Lunch

Day 3: PM

What are your favorite foods? _____

How often do you eat them? _____

What foods, if any, do you crave? _____

Do you feel tired after eating (especially sugar-containing foods)? _____

How often do you eat fish such as salmon, cod or trout? _____

Do you eat fresh, raw fruits and vegetables daily? _____

Average total number of servings of fruits and vegetables daily? _____

What foods do you like to snack on? _____

How much water do you drink daily? _____ **How much pop daily?** _____ **Coffee?** _____

Do you use aspartame, saccharin or other artificial sweeteners? _____

How many meals per week do eat out (on average)? _____

How often do your bowels move? _____

Do you use laxatives or stool softeners? if so how often and what kind? _____

How much time per week are you physically active? _____

SELF EVALUATION:

Where do you think your diet needs most improvement? _____

GENERAL HEALTH CONCERNS: Please check "✓" any of the following you are concerned about:

- | | | |
|-------------------------------------|--------------------------------------|-------------------------------------|
| Acne _____ | Digestive complaints _____ | Menopause _____ |
| Addictions _____ | Dizziness _____ | Mood swings _____ |
| Adrenal fatigue _____ | Dry skin or itching _____ | Nervousness _____ |
| Aging _____ | Eating disorder _____ | Night sweats _____ |
| Allergies _____ | Fatigue or loss of energy _____ | Night terrors _____ |
| Anger _____ | Fibromyalgia _____ | Numbness (neuropathy) _____ |
| Antibiotic use _____ | Food or sugar cravings _____ | Where? _____ |
| Anxiety _____ | Food sensitivities _____ | Obsessive compulsive disorder _____ |
| Asthma _____ | Fungus (inc. athletes foot) _____ | Overeating _____ |
| Back pain _____ | Gas (flatulence)? _____ | PMS _____ |
| Bloating/water retention _____ | Glaucoma _____ | Prostate support _____ |
| Bone loss (osteoporosis) _____ | Glucose intolerance _____ | Salt cravings _____ |
| Bruise easily _____ | Gout _____ | Sex drive (lack of) _____ |
| Cancer _____ | Gum disease _____ | Sinusitis/hayfever _____ |
| (Type?) _____ | Gums that bleed _____ | Sleep problems _____ |
| Candida (Yeast infection) _____ | Hair loss or breakage _____ | Do you dream? _____ |
| Carbohydrate (sugar) craving _____ | Headaches _____ | Do you notice you sleep deeply |
| Carpal Tunnel _____ | Hearing loss _____ | from 7 - 9 am _____ |
| Cataracts _____ | Heart disease _____ | Slow wound healing _____ |
| Cholesterol levels (elevated) _____ | High blood pressure _____ | Stress _____ |
| Circulation (cold hands/feet) _____ | Hives _____ | TMJ _____ |
| Cold sores _____ | Hot flashes _____ | Weight problems _____ |
| Confusion/mental fuzziness _____ | Immune system support _____ | Other: _____ |
| Constipation _____ | Irritable Bowel Syndrome _____ | _____ |
| (bowels do not move every day) | Joint pain _____ | _____ |
| Depression _____ | Liver support _____ | _____ |
| Diabetes _____ | Low blood sugar (hypoglycemia) _____ | |
| Diarrhea _____ | Memory loss _____ | |

List any specific nutritional supplements you would like more info on? _____

NAME: _____

EVALUATION / COMMENTS / RECOMMENDATIONS:

DATE: _____

General: _____

Goals: 1. _____

2. _____

3. _____

4. _____

5. _____

Diet:

Fruit/Vegetable Servings: _____

Protein: Intake: _____

Complex Carb Intake: _____

Essential Fatty Acid Intake: _____

Trans Fat intake: _____

Fiber: _____

Sugar/Refined Foods: _____

Other: _____

Supplement:

Suggested Dosage:

Purpose:

You may choose to implement any or all of the above suggestions... God Wants You Well!

Complementary and Alternative Health Care Client Bill of Rights

Please read this Complementary and Alternative Health Care Client Bill of Rights. I am pleased to provide you with this Client Bill of Rights, in accordance with Minnesota laws, Statute 146A, governing complementary and alternative health care practices.

Beth M. Ley. Ph.D.; NHL Ministries, On line and in person nutritional counseling.

Degrees, Training, Experience and Qualifications:

Masters (1998) and doctorate (1999) degrees in Natural Health from Clayton College of Natural Health
B.S. (1987) in Scientific and Technical Writing from North Dakota State University

In accordance with Minnesota state law, I am providing you with the following notice:

" THE STATE OF MINNESOTA HAS NOT ADOPTED ANY EDUCATIONAL AND TRAINING STANDARDS FOR UNLICENSED COMPLEMENTARY AND ALTERNATIVE HEALTH CARE PRACTITIONERS. THIS STATEMENT OF CREDENTIALS IS FOR INFORMATION PURPOSES ONLY. UNDER MINNESOTA LAW, AN UNLICENSED COMPLEMENTARY AND ALTERNATIVE HEALTH CARE PRACTITIONER MAY NOT PROVIDE A MEDICAL DIAGNOSIS OR RECOMMEND DISCONTINUATION OF MEDICALLY PRESCRIBED TREATMENTS. IF A CLIENT DESIRES A DIAGNOSIS FROM A LICENSED PHYSICIAN, CHIROPRACTOR OR ACUPUNCTURE PRACTITIONER, OR SERVICES OF A PHYSICIAN, CHIROPRACTOR, NURSE, OSTEOPATH, PHYSICAL THERAPIST, DIETITIAN, NUTRITIONIST, ACUPUNCTURE PRACTITIONER, ATHLETIC TRAINER OR ANY OTHER TYPE OF HEALTH CARE PROVIDER, THE CLIENT MAY SEEK SUCH SERVICES AT ANY TIME."

3. Right to file a complaint. If you have any concerns, you may file a complaint with the following office.

Office of Unlicensed Complementary and Alternative Health Care Practice
Health Occupations Program
Suite 300, Golden Rule Building
P.O. Box 64882
St. Paul, MN 55164-0882

Phone: 651-282-6331
Toll Free: 1-800-657-3957
Fax: 651-282-3839

4. Fees per unit of service, names of insurance companies with reimbursement to practitioner, HMO relationships, whether practitioner accepts Medicare, medical assistance, or general assistance medical care; whether willing to accept partial payment or waive payment and in what circumstances. (For example: Fees are payable at the time of service. We do not handle insurance claims; however, a receipt can be provided upon request to you, should you wish to file a claim with your provider. I do not accept Medicare, Medical Assistance or General Assistance medical care.

5. Change in service or charges. You have the right to reasonable notice of changes in services or charges, and I will provide prior notice of any changes.

6. Brief summary of my Theoretical Approach.

I believe the body was designed (by God, the Creator) to heal itself. I believe the Word of God gives us instruction on what foods to eat to obtain and maintain health. I believe dietary changes, lifestyle changes and supplements can be used to help restore our health, not looking to supplements to be "the answer" but always looking to the WORD of God and Jesus for wisdom as our Healer.

7. Assessment and Recommendations. You have the right to complete and current information concerning my assessment and recommended service, including the expected duration of the services to be provided. If you have any questions, please ask.

8. Courteous Service. You may expect courteous treatment and to be free from verbal, physical or sexual abuse by your practitioner.
9. Confidentiality. Your records and transactions with this office are confidential. This information will not be released unless you authorize release in writing, or unless release is required by law.
10. Records. You are allowed access to records and written information from records in accordance with section 144.335 of Minnesota Statutes.
11. Other Community Services. Other similar services are available in the community. Possible sources of information are Minnesota Wellness Directory, the Edge newspaper directory, or the telephone yellow pages. You may ask your practitioner and she will provide this information to the best of her knowledge.
12. Selecting and Changing Practitioners. You have the right to choose freely among available practitioners and to change practitioners after services have begun, within the limits of health insurance, medical assistance or other health programs. If these services are covered by your health insurance, medical assistance plan or other health program, you should direct all questions about coverage to your health insurance provider.
13. Coordinated transfer. If you change practitioners, you have the right to our assistance in coordinating this transfer to another practitioner.
14. Right to Refuse Service. You are free to refuse services or recommendations made.
15. No Retaliation. You may assert your rights described in this Client Bill of Rights at any time without retaliation.

ACKNOWLEDGMENT: I have received a copy of the Complementary and Alternative Client Bill of Rights. I have read and understand the Client Bill of Rights, or it has otherwise been read to me. I have had a full opportunity to ask any questions I have about this document and my rights as a client. I understand my rights as a client.

 Client or Legal Guardian's Name (Printed)

 Date

 Client or Legal Guardian's (Signature)

 Date

 Relationship to Client