EXCELLIS
NUTRITION

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CONSENT FOR TREATMENT
AND AUTHORIZATION FOR USE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ DOB: _____

Parent/Guardian Name: _____
(Applies for patients under 18)

I hereby consent to participating in nutrition counseling with Excellis Nutrition LLC and understand that all information I provide is private, confidential, and protected by law. When necessary to coordinate my nutrition and healthcare my protected health information may be obtained from and/ or provided to my:

- ☐ Primary Care Doctor: _____
  Address: _____
  _____
  Phone: _____ Fax: _____

- ☐ Other Doctor(Relationship): _____
  Address: _____
  _____
  Phone: _____ Fax: _____

Excellis Nutrition LLC and Stacie Ellis PhD, RDN, LD is hereby released from legal responsibility or liability for the release of information authorized here in. I understand that I have the right to revoke this authorization in writing at any time by sending notification to Stacie Ellis PhD, RDN, LD. I understand that I have the right to (1) inspect or obtain a copy of the protected health information to be provided as permitted under federal and state law, and (2) refuse to sign this authorization. My signature indicates understanding and acceptance of the above policies.

Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____
(If patient is under 18)

HIPAA Acknowledgement

By signing below I acknowledge that I received a copy of my rights as described in Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____
(If patient is under 18)

CONSENT FOR TELEHEALTH

Telehealth involves the use of electronic communications to enable providers at different locations to share individual client information for the purpose of improving client care. The information may be used for diagnosis, therapy, follow-up and/or education, and may include health records, live two-way audio and video, or output data from health devices and sound and video files.

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of client identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

Possible Risks:

There are potential risks associated with the use of telehealth. In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate decision making by the providers and consultant(s). In very rare instances, security protocols could fail, causing a breach of privacy of personal health information.

By signing, you agree to the usage of telehealth and understand the following:

1. I understand that the laws that protect privacy and the confidentiality of health information also apply to telehealth, and that no information obtained in the use of telehealth which identifies me will be disclosed to researchers or other entities without my consent.
2. I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment.
3. I understand that I have the right to inspect all information obtained and recorded in the course of a telehealth interaction and may receive copies of this information for a reasonable fee.
4. I understand that telehealth may involve electronic communication of my personal health information to other practitioners who may be located in other areas, including out of state.
5. I understand that I may expect the anticipated benefits from the use of telehealth in my care, but that no results can be guaranteed or assured.

Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____
(If patient is under 18)

CONSENT FOR EMAIL/ TEXT CORRESPONDENCE

Email/text communication is a convenient form of communication among individuals, however; transmitting information by email/text can create a number of risks. By signing you are allowing the usage of correspondence via email/text and acknowledging the risks involved in such communication and release Excellis Nutrition LLC from any liability associated with such risks.

Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

CONSENT FOR RESEARCH

Continued nutrition research is a vital part of improving the health and wellbeing of individuals. Dr. Ellis and her colleagues continue to work on finding new ways to reach the general public, and you can be a part of these efforts. By signing below, you agree to allow any information that is obtained from your treatments to be used for future research purposes. All identifier information will be removed from all data that is used for such studies to protect your rights as a patient. You have the right to opt out of future research at any time, and you have the right to any data that has been collected on you.

Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

CONSENT FOR MARKETING

Nutrition education is needed to reach the general public. One of these ways of doing this is through marketing efforts. Marketing efforts through Excellis Nutrition may be in the form of advertisements, speaking engagements, health fairs, social media posts, posts on the website, or hard copy marketing materials. Sharing experiences from current patients can be helpful at motivating others to change their lifestyle habits. By signing below you are allowing some of your experiences to be used for marketing purposes. Experiences include quotes, positive outcomes, and shared experiences that can relate to our target audience. All identifier information will remain confidential and HIPPA compliant. Clients are welcome to share actual testimonies, pictures, or experiences that they would like to share for future marketing purposes as well, but this is optional.

Please sign if you are willing to use your experience for future marketing purposes.

Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

_____Please initial if you are open to using direct quotes with your first and last initial for marketing purposes.

_____Please initial if you are open to the use of photographs or videos of yourself for future marketing purposes. You will be contacted for a second approval before such items are used.

NEW PATIENT/CLIENT REGISTRATION

Client Name: _____ Date of Birth: _____

Name of individual responsible for charges: _____

Phone (if different from client): _____

***Client Information*:**

Address: _____

Phone: Home _____ Cell _____

Work _____ Other _____

Email Address: _____

Preferred contact method: _____

Marital Status: _____ Number of People in Household: _____

Occupation: _____ Employer: _____

Insurance: _____

Member Name: _____

Member ID: _____

Group Number: _____

Reason for visit today_____

How did you hear about Excellis Nutrition? □ Google □ HealthProff.com □ EatRight.org
□ Referral by healthcare practitioner □ Referred by friend □ Other_____

Referred by:_____

Acceptance of Registration Information

I hereby accept the registration information written above as accurate and acknowledge this information will be used to guide the Registered Dietitian in preparing my personalized plan of care.

_____

Signature of New Patient/Client *Date*

HEALTH INFORMATION

Client Name: _____
Age: _____ Sex: _____ Race(for genetic purposes) _____
Height: _____ Current Weight: _____ Usual Weight: _____

Length of time at current weight: _____
Lowest weight at current height: _____ When?: _____
Highest weight at current height: _____ When?: _____
Are you satisfied with your current weight? Yes ___ No ___
What do you consider your "ideal" weight? _____
Do you gain or lose weight regularly? Yes ___ No ___
Briefly provide any additional information regarding your weight history here:
_____
_____
_____
_____

Body Fat % (optional) _____ Date measured: _____
Type measure (circle one)

DXA	Skin fold	Hydrostatic/underwater weighing
Ultrasound	3-D body scan	InBody(bioelectrical impedance (BIA))
Scale with BIA	BIA hand held	Bod Pod

If you have a copy of your Body Fat measurement report, please attach a copy.

Do you smoke? Yes ___ No ___
If yes, what do you smoke and how much per day? _____

Date of last physical: _____ Do you have labs: □ Yes (please attach a copy) □ No
If you have no labs available, were their any labs that your doctor notified you in the past that were a concern? If so please specify in the above table.

Medications/supplements/ herbals: Please list any medications, supplements (vitamins, performance supplements, protein powders, protein bars, etc.) and herbals you are currently taking. Add additional pages if needed.

Medication/Supplement/herbal	Dosage	How often do you take?

Medical History

Have you ever been diagnosed with any of the following? Check all that apply

□ hypertension (high blood pressure) □ heart disease □ metabolic syndrome

□ Diabetes- specify □ type 1 □ type 2 □ gestational

□ Pre- diabetes □ hypoglycemia

□ kidney disease-specify □acute □ chronic stage □1 □ 2 □ 3 □ 4 □been on dialysis

□ pulmonary disorder (ex: COPD, asthma) □ osteoporosis /low bone mass

□ arthritis □ Auto immune disorder- specify _____

□ Cancer- specify _____

□ severe acne □constipation □diarrhea

□ anemia-specify □iron □ vitamin B12 □ vitamin B6

□ disordered eating patterns (such as stress/emotional eating)

□ eating disorder- specify □ anorexia □bulimia □ binge-eating □ night eating syndrome
□ avoidant/restrictive food intake disorder □purging disorder
□ atypical anorexia □bulimia low frequency/duration
□ orthorexia □pica □body dysmorphia

□ Reproductive condition- specify □PCOS □ Endometriosis □Fibroids □Amenorrhea
□ Functional Hypothalamic Amenorrhea □ Oligomenorrhea
□ Dysmenorrhea (painful periods) □ menorrhagia (heavy bleeding)
□ metrorrhagia (bleeding at irregular intervals between periods)
□ hypomenorrhea (light periods)
□ Premenstrual Syndrome □ Premenstrual dysphonic disorder

□ food intolerance- (ex. Lactose, gluten) specify _____

□ food allergies- specify _____

□ food sensitivities- specify _____

□ digestive problems, please specify:

_____

□ thyroid problems, please specify:

_____

□ diagnosed mental health conditions please specify:

_____

□ other conditions, please specify:

_____

□ abnormal labs

□ Glucose- specify value_____ fasted? □yes □ no

□ HbA1c – specify value _____

□ Insulin □low □high

□ low vitamin D levels □low iron or ferritin level □ Low B12 □ low B6

□ low prealbumin, albumin, or CK □ low electrolytes (Mg, Ca, K, Na, CL)

□ Elevated CRP □ elevated TNF-α, IL-6, IL-1, IL-17, IFNγ, or B Cells

□ abnormal hormone levels- specify □high estrogen □ low estrogen
□ high testosterone □ low testosterone
□ low progesterone □ low LH
□ low AMH □ Low FSH
□elevated cortisol □ thyroid hormones

□ high cholesterol/ blood lipids- specify □ high LDL □low HDL □ High TG

□ other abnormal labs _____

Holistic Health: For the next section, respond by circling the appropriate response based off of how you personally feel you are doing with each one.	Poor	Average	Excellent
Psychological health (mental health)	□	□	□
Emotional health (mood, happy, sad, angry, etc.)	□	□	□
Spiritual health (religion, self-reflection, volunteering in community, meaning, etc.)	□	□	□
Personal life (time for self, time with friends and family, hobbies, self-care, etc.)	□	□	□
Professional (time for lunch, boundaries, not overworked, time off, support, fulfillment, etc.)	□	□	□
School/college (workload, time management, academic success, etc.)	□	□	□

Feel free to further explain any answers here and any of its effects on your eating: _____
_____
_____
_____
_____
_____
_____
_____

Exercise History:

Which of the following primarily describes your work, school, or daily activity? (This questions doesn't include structure exercise)

□Sitting □Standing □Walking or other active motion □Heavy labor (heavy lifting)

Do you currently exercise? □Yes □ Yes, but not consistently □No

If yes, please specify what kind of activity, how many minutes and how many days a week.

Activity: _____

How long and how often: _____

_____

If you do resistance training, please specify your workout split. Include the number of exercises per session, number of reps and sets. Do you train heavy, moderate, or light weights? _____

_____

What is your goal with your workouts? _____

_____

Are you new to exercising? □Yes □No

If no, how many years/months have you been exercising?_____

Are you working with a trainer? _____

Sleep

How many hours of sleep do you typically get a night? _____

Do you have a set sleeping schedule? ☐Yes ☐No

What time do you normally go to bed at night? _____

What time do you normally wake up? _____

Do you nap during the day? ☐Yes ☐No

Other than mid to late afternoon, do you feel tired throughout the day? ☐Yes ☐No

Optional: You may go to the following link to determine your chronotype. What was your chronotype results.

☐ definite evening ☐ moderate evening ☐ intermediate ☐ moderate morning ☐ definite morning

Note: Definite evening like to go to bed roughly around 2:30-3am and wake up around 11am. Moderate evening goes to bed around 12:30-1am and wakes up 9-9:30 . Intermediate likes to go to bed around 10-11pm and wake up around 7:30am . Moderate morning likes to go to bed around 9:30pm and wakes up around 5:30-6apm. Definite morning likes to go to bed around 8pm and wake up around 4am.

For Women only:

Do you currently have a regular menstruation? □Yes □No

If no, please explain: _____

Note- A regular cycle indicates having your period the same number of days each month with only a slight variation of 1-2 days. For example, a consistent 28-30 day cycle, or a consistent 35-37 day cycle.

Do you have a history of irregular menstruation. □Yes □No

If yes, please explain when and its irregularity: _____

_____

Note- Irregularity means the time of your cycle varies in length from month to month. For example one month it is 28 days, the next month it is 32 days, the next month it is 36 days, etc.

Do you currently or previously have issues with heavy bleeding? □Yes □No

Is this a current issue? □Yes □No

Note- Heavy bleeding is defined as having to change your pad, tampon, or cup in less than 2 hours or losing more than 1/3 cup of total blood.

Do you have very painful periods? □Yes □No

Note- Painful periods can result in you staying home from school or work.

Do you frequently exhibit migraines after ovulation or as a PMS symptom □Yes □No

Do you experience PMS symptoms (i.e. bloating, tender breast, digestive issues, irritability, anxiety, etc.) □Yes □No

Do you experience bleeding between your cycles, particularly after ovulation. □Yes □No

With any of the above situations, did you see a doctor to help resolve the issue? □Yes □No

If yes, did the doctor prescribe birth control in order to regulate your cycle? □Yes □No

If yes, are you currently using birth control to regulate your cycle. □Yes □No

Do you currently track your cycle □Yes □No

How often do you have your period?

□I am very regular (every 24-35 days)

□ I am more frequent (every 14-23 days)

□ I am less frequent (every 36-45 days)

□ I do not have a menstrual cycle (no cycle for longer than 3 months)

□ I am not sure how often I have my period

Note: a cycle includes the days of your period. So a 28 day cycle may include 3-5 days of a period and then also the days when you are not on your period. Your cycle begins on day 1 of your period.

Are you currently pregnant? □Yes □No

Are you currently nursing? □Yes □No

DIET AND EATING HABITS

Please indicate whether you have ever used any of these methods to control your body weight (check all that applies).

Method	**When did you do this**	**Length of time used**
□fasting		
□skipping meals Specify meals: _____		
□ intermittent fasting Specify eating window _____		
□commercial weight loss programs Specify: _____		
□liquid supplements (ex: slim fast) Specify: _____		
□very low calorie diet (<1200 kcal/d) Calories consumed _____		
□self- induced vomiting		
□laxatives or diuretics		
□diet pills or "fat-burning" supplements		
□excessive exercise Specify _____ _____ _____		
□low fat diet/ high carbohydrate diet		
□high protein diet/ low carbohydrate diet		
□ high fat diet such as keto, Atkins, Zone diet		
□vegetarian/ vegan/pescatarian diet for the purpose of weight control Specify type: _____		
□nutritional counseling (ex: with a dietitian or nutritionist)		
□ Calorie counting Calories consumed: _____		
□ Other: _____		

Do you have any foods you <u>do not</u> eat for any reason? Yes ___ No ___

If yes, please specify: _____

Are there any foods that you would find difficult NOT to eat? Yes ___ No ___

If yes, please specify: _____

Have you ever been on any special diet? Yes ___ No ___

If yes, what kind of diet(s)? _____

When? _____

Was there any component of the diet(s) that worked well? _____

_____

Have you changed your eating habits or appetite in the last 6 months? Yes ___ No ___

If yes, please explain: _____

Do you feel you are an emotional eater? □ Yes □No

If yes, please explain: _____

_____

How much and what kinds of foods do you eat during these times? _____

_____

How often does this occur? (Circle one)

Daily 1 x a week 2-3x a week 4-6x a week 1x a month 2-3x a month Occasionally

Describe your present appetite. (Circle one)

Very good Good Okay Poor Very Poor

How is most of the food you eat cooked?

Boiled ___ Fried ___ Baked ___ Broiled ___ Grilled ___ Sauté ___

Other: _____

Who cooks the meals in your home? _____

How often do you have a home cooked meal (including leftovers)? _____

Do you use salt during cooking? _____ At the table? _____

What type of milk do you drink?

Skim 1% 2% Whole Buttermilk Flavored Milk Oatmilk

Almond Milk Soymilk Rice Milk None – I don't drink milk

Other: _____

How often do you drink it? _____

What beverages do you normally drink during the day? _____

How much do you drink a day? _____

Do you drink beer, wine or any other alcohol? Yes ___ No ___

If yes, what do you drink? _____

How much and how often? _____

How often do you get fast food during the week? _____

List some of the fast-food places you would go to and what you would order _____

_____

_____

How often do you eat at a sit-down restaurant during the week? _____

List some of the restaurants you would go to and what you would order _____

_____

_____

Please describe how you normally eat on a typical day. Please specify the amount, brands, and types of food. Please include what time you normally eat as well:

Time	Meal
	Morning meal
	Mid-day meal
	Evening meal
	Snacks

Briefly describe what you hope to learn from this session: _____

_____

_____

_____

If there is anything else you would like to share, please feel free to comment.

_____

_____

_____

FOOD DIARY (RECOMMENDED, BUT OPTIONAL)

To help the RD get a better idea of your typical diet please complete this 3 day food diary and bring it to your appointment.

3 Day Food Diary Directions
Please record all food and drink, for 3 days, 2 weekdays and 1 day during the weekend. It is easiest to record correctly if recording is done directly after a meal or snack.

1. Describe the food accurately and give brand names if possible. For example: margarine (Blue Bonnet soft tub) 1 teaspoon levels with knife.

2. Please record any foods that state they are fortified with additional vitamin D or calcium.

3. State whether fruits and vegetables are fresh, canned (water pack, heavy or light syrup), cooked or frozen.

4. Record the amount of food eaten by using household measures such as cups, teaspoons, tablespoons, or weigh the food. For example: Whole milk ½ cup or 4 ounces (oz) 2% cottage cheese or 4 level tablespoons.

5. For meat every oz is about the size of a match box. 3 oz is about the size of a deck of cards. Keep in mind the bone takes up space. For example: Broiled pork chop with bone = 3 ounces, bone weight is 1 ounce, so total weight of pork chop is 2 ounces.

6. Describe sandwiches in detail.
For example: Bologna sandwich: 2 slices of whole wheat bread, 1 slice (1 ounce) bologna, 1 level tablespoon Kraft Mayonnaise (lite or regular), 1 lettuce leaf, 1 slice (1 ounce)Processed cheese (Kraft)

7. Be sure to record amounts of additional foods served with cereals or desserts, etc.
For example: Cereal: ½ cup Rice Krispies (Kellogg's), ¼ cup milk 2%, 2 level tablespoons Brown Sugar

8. Include how the food is prepared especially for meats, fish, poultry, eggs, and vegetables. Methods of preparation include boiling, roasting, baking, broiling, frying or steaming. When frying, be sure to mention the type of fat or oil used.

9. If eating out, describe food item well. Please record the name of popular fast food restaurants as we have nutrition information for all foods

10. Please include any vitamins and minerals you consume.

http://remakemyplate.com/resources-tips-and-tools/size-it-up-portion-sizes/

3 Day Food Diary
Date: Example

Time	Food/drink eaten	How hungry before meal (1-5, 1=very hungry, 2=hungry, 3=neutral, 4=satisfied, 5= full)	Mood before meal	How hungry after meal (1-5, 1=very hungry, 2=hungry, 3=neutral, 4=satisfied, 5= full)	Mood after meal
8:15am	*1 cup cereal, 1 cup 1% milk, 1 large banana, 1 cup coffee with 1 tsp sugar*	*1*	*tired*	*4*	*Slightly awake*
10:30	*Granola bar*	*3*	*bored*	*4*	*Slightly happy*
12:30	*Sandwich- 2 slice whole wheat bread, slice of American cheese, 2oz of lean ham deli meat, lettuce, tomato, 2 tbsp mayo* *1 oz Doritos chips* *1 small cookie* *½ cup apple sauce* *8 oz water*	*2*	*annoyed*	*5*	*happy*
2:00	*1 fun size snickers bar, 8 oz water*	*3*	*happy*	*3*	*happy*
5:00	*16 oz Gatorade*	*3*	*Bored*	*4*	*Bored*
6:00	*3 oz chicken breast, 1 cup mash potatoes, 1 tsp butter, ½ cup canned green beans, ½ cup corn, 1 cup apple juice*	*2*	*tired*	*5*	*neutral*
7:00	*6oz cup of flavored Greek yogurt*	*3*	*Happy*	*4*	*happy*

Time	Physical Activity	How long	Intensity
2:30	*Ballet- Advance level*	*1hr 30 min*	*low*
4:30	*Gym- weights lower body and back*	*45 min*	*high*

3 Day Food Diary
Date:

Time	Food/drink eaten	How hungry before meal	Mood before meal	How hungry after meal	Mood after meal
Time	Physical Activity	How long	Intensity		

3 Day Food Diary
Date:

Time	Food/drink eaten	How hungry before meal	Mood before meal	How hungry after meal	Mood after meal
Time	Physical Activity	How long	Intensity		

3 Day Food Diary
Date:

Time	Food/drink eaten	How hungry before meal	Mood before meal	How hungry after meal	Mood after meal
Time	Physical Activity	How long	Intensity		