Nutrition and Wellness Counseling

This is an ongoing service for patient consults with Dr. Beth Ley Knotts, via email, phone and Skype.

Payment methods: MC, VISA, Discover, PayPal or checks payable to NHL Ministries.

CC# _____

Exp date: _____ *CVR* _____

Payment plans are available through PayPal.

*PayPay-linked email:*_____

Ongoing consults for 3 months: $225.00

One-Time Consult Option: $90.00

NHL Ministries **beth m. ley, ph.d.**

Medicare NPI: 1467765172

218-363-6719 email bley@blpublications.com

www.recipesforlifewithdrbeth.com

Email or Phone Appointments Available

Please mail completed questionnaire and payment to

NHL Ministries 4851 Hausken Trail NE, Longville, MN 56655

OR scan and email.

Referred by _____ *Date* _____

Additional charges will apply if supplements or other supplies are purchased.

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 advise, 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 fax, email or mail to address above 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)

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? What are your goals? _____

_____

_____

_____

_____

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

_____

_____

_____

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? _____

What foods, if any, do you crave? _____

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

How often do you eat fish high in Omega-3's (salmon, cod, trout, tuna steak)? _____

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

What foods do you like to snack on? _____

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

What kind of water do you drink? (well, spring, tap, RO, distilled?) _____ pH of water?____

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

How many hours do you sleep per night? _____

Rate your current level of stress from 1-10:_____

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?_____

Do you have any special dietary needs? (ex. gluten-free, dairy-free, allergies, etc.) _____

_____

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:

Acid Reflux_____
Acne_____
Addictions _____
Adrenal fatigue_____
Aging _____
Allergies _____
Anger _____
Antibiotic use _____
Anxiety _____
Asthma _____
Back pain _____
Bloating/water retention _____
Bone loss (osteoporosis) _____
Brain Fog/Slow thinking_____
Bruise easily _____
Cancer _____
(Type?) _____
Candida (Yeast infection) _____
Carbohydrate (sugar) craving_____
Carpal Tunnel _____
Cataracts _____
Cholesterol levels (elevated) _____
Circulation (cold hands/feet) _____
Cold sores _____
Cold sensitivity _____
Confusion/mental fuzziness _____
Constipation _____
(bowels do not move every day)
Depression _____
Diabetes _____
Diarrhea _____
Digestive complaints _____
Dizziness_____
Dry skin or itching _____
Eating disorder _____
Fatigue or loss of energy _____
Fibromyalgia _____
Food or sugar cravings _____
Food sensitivities _____
Frequent urination _____
Fungus (inc. athletes foot) _____
Gas (flatulence)? _____
Glaucoma _____
Glucose intolerance_____
Gout _____
Gum disease _____
Gums that bleed _____
Hair loss or breakage _____
Headaches _____
Hearing loss_____
Heart disease _____
Heat sensitivity_____
High blood pressure _____
Hives_____
Hot flashes _____
Immune system support _____
Inflammation _____
Elevated CRP? _____
Irritable Bowel Syndrome _____
Joint pain _____
Kidney health_____
Leeky gut _____
Liver support _____
Low body temp _____
Low blood pressure _____
Low blood sugar (hypoglycemia) ____
Memory loss _____
Menopause_____
Migraines _____
Mood swings _____
Nervousness _____
Night sweats _____
Night terrors _____
Numbness (neuropathy)_____
Where? _____
Obsessive compulsive disorder_____
Overeating _____
PMS _____
Prostate support _____
PTSD_____
Random Pains _____
Gut? _____
Muscular? _____
Other? _____
Restless Leg Syndrome _____
Salt cravings _____
Sex drive (lack of) _____
Sinusitis/hayfever _____
Sleep problems _____
Wake up a lot? _____
Trouble falling asleep?_____
Do you dream? _____
Do you notice you sleep deeply from 7 - 9 am _____
Slow wound healing _____
Stress _____
Stress Sensitivity _____
Thirst _____
Thrush _____
Thyroid _____
TMJ_____
Weight problems _____
Other:_____
_____
_____
Do you use sunblock? _____
Do you know your Vitamin D level?
_____

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, phone 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 MN 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