

Nutrition and Wellness Counseling

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

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: \$265.00

One-Time Consult Option: \$120.00

NHL Ministries beth m. ley, p.h.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 _____

Please indicate One-time or Ongoing consults. 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 _____ | Food or sugar cravings _____ | Numbness (neuropathy) _____
Where? _____ |
| Acne _____ | Food sensitivities _____ | |
| Addictions _____ | Frequent urination _____ | Obsessive compulsive disorder _____ |
| Adrenal fatigue _____ | Fungus (inc. athletes foot) _____ | Overeating _____ |
| Aging _____ | Gas (flatulence)? _____ | PMS _____ |
| Allergies _____ | Glaucoma _____ | Prostate support _____ |
| Anger _____ | Glucose intolerance _____ | PTSD _____ |
| Antibiotic use _____ | Gout _____ | Random Pains _____
Gut? _____
Muscular? _____
Other? _____ |
| Anxiety _____ | Gum disease _____ | Restless Leg Syndrome _____ |
| Asthma _____ | Gums that bleed _____ | Salt cravings _____ |
| Back pain _____ | Hair loss or breakage _____ | Sex drive (lack of) _____ |
| Bloating/water retention _____ | Headaches _____ | Sinusitis/hayfever _____ |
| Bone loss (osteoporosis) _____ | Hearing loss _____ | Sleep problems _____
Wake up a lot? _____
Trouble falling asleep? _____
Do you dream? _____
Do you notice you sleep deeply
from 7 - 9 am _____ |
| Brain Fog/Slow thinking _____ | Heart disease _____ | Slow wound healing _____ |
| Bruise easily _____ | Heat sensitivity _____ | Stress _____ |
| Cancer _____
(Type?) _____ | High blood pressure _____ | Stress Sensitivity _____ |
| Candida (Yeast infection) _____ | Hives _____ | Thirst _____ |
| Carbohydrate (sugar) craving _____ | Hot flashes _____ | Thrush _____ |
| Carpal Tunnel _____ | Immune system support _____ | Thyroid _____ |
| Cataracts _____ | Inflammation _____
Elevated CRP? _____ | TMJ _____ |
| Cholesterol levels (elevated) _____ | Irritable Bowel Syndrome _____ | Weight problems _____ |
| Circulation (cold hands/feet) _____ | Joint pain _____ | Other: _____

_____ |
| Cold sores _____ | Kidney health _____ | Do you use sunblock? _____ |
| Cold sensitivity _____ | Leaky gut _____ | Do you know your Vitamin D level?
_____ |
| Confusion/mental fuzziness _____ | Liver support _____ | |
| Constipation _____
(bowels do not move every day) | Low body temp _____ | |
| Depression _____ | Low blood pressure _____ | |
| Diabetes _____ | Low blood sugar (hypoglycemia) _____ | |
| Diarrhea _____ | Memory loss _____ | |
| Digestive complaints _____ | Menopause _____ | |
| Dizziness _____ | Migraines _____ | |
| Dry skin or itching _____ | Mood swings _____ | |
| Eating disorder _____ | Nervousness _____ | |
| Fatigue or loss of energy _____ | Night sweats _____ | |
| Fibromyalgia _____ | Night terrors _____ | |

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