Waiver for Nutrition Counseling

Focused Nutrition LLC and Denise Tripolone, FNS, is not a physician or psychologist and the scope of nutrition counseling does not include treatment or diagnosis of specific illnesses or disorders. If you, the client, suspect you may have an ailment or illness that may require medical attention, then you are encouraged to consult with a licensed physician without delay. Only a licensed physician can prescribe drugs. Any mention of medications in the course of consultation is only for the purpose of providing a complete history of medications that the client is taking and not Focused Nutrition LLC and Denise Tripolone, FNS, to judge the appropriateness of the medication. Before any change in prescription or dosage is made, Focused Nutrition requires the client to consult with his or her physician.

In consideration of my participation in the Nutrition Counseling, I hereby accept all risk to my health and of my injury or death that may result from such participation and I hereby release Focused Nutrition LLC and Denise Tripolone, FNS, from any liability to me, my personal representatives, estate, heirs, next of kin, and assigns for any and all claims and causes of action for loss of or damage to my property and for any and all illness or injury to my person, including my death, that may result from or occur during my participation in the Nutrition Counseling, whether caused by negligence of Focused Nutrition LLC and Denise Tripolone, FNS, or otherwise. I further agree to indemnify and hold harmless Denise Tripolone, FNS from liability for the injury or death of any person(s) and damage to property that may result from my negligent or intentional act or omission while participating in the described Nutrition Counseling session.

Supplemental Communication

Supplemental Phone consultations can be scheduled between sessions. Focused Nutrition operates Monday - Friday 7am - 6pm PST. Should you choose to email (non-secure) I will read your emails but may not be able to respond by email depending upon the private nature of the information within. If nessecary, we can discuss the content of your note at our next session. If you require longer than a few minutes, please consider setting up an extra session. If there is an emergency, please call 911 or go to the nearest emergency room and/or hospital.

Session Time

Regular sessions are 30-45 minutes in length. Focused Nutrition will make every attempt to begin sessions on-time and we appreciate your cooperation in beginning and ending them on-time.

Payment

It is preferable for Focused Nutrition to receive payment at the time of your session. Please have your preferred payment method established before the session begins. In some cases, Focused Nutrition understands it is necessary to bill you or another party for services. Focused Nutrition is willing to cooperate with you in that regard. Virtual Pay, Credit Card, Check and Cash are accepted. There is a **$30.00 fee** for any return check or insufficient funds transfer.

Fees
Initial appointment cost: $150
Follow-up appointments: $75

Price is subject to change without notice

Cancellations
A 24-hour notice is required for **ALL** cancellations. Focused Nutrition will charge you for any appointment which is cancelled without the 24-hour notice. We appreciate your understanding and cooperation.

By signing below, you acknowledge that you understand that _____ is a health consultant and not a physician, and that you should see a doctor if you think you have a medical condition. _____ will not be held liable for failure to diagnose or treat an illness, nor will she be liable for failure to prevent future illness.
Additionally, you promise to give _____ a complete and accurate account of any medical conditions that you may have and any medications that you are taking.
Office Policy

Signature of client: _____Date: ___/___/___

Nutrition and Health History Questionnaire

Part I. General Information

Evaluation Date_____ Name_____
Age_____Height_____Weight_____Phone_____
Address:_____
Email Address:_____
What are your wellness/nutrition goals? (check all that apply)
_____ Feel better overall, improve metabolism
_____ Improve nutritional habits (e.g., eat fewer sweets, eat more vegetables, control portions)
_____ Develop better lifestyle skills (e.g., plan meals, make smart food choices)
_____ Lose weight (If checked, include weight loss goal :_____)
_____ Lower cholesterol
_____ Improve high blood pressure
_____ Improve blood glucose (sugar) levels
_____ Reduce stress
_____ Improve cardiovascular fitness
_____ Improve muscle strength and conditioning
_____ Other (please specify)_____
Have you seen a nutritionist in the past? _____No _____Yes
If yes, how long ago and for what condition?
_____
_____
Was it resolved? _____No _____Yes

Part II. Medical History

Do you have, or have you ever had, any of the following medical conditions?
_____Arthritis
_____Heart Disease
_____Lung Disease
_____Autoimmune Disease
_____Cancer
_____Diabetes
_____High Blood Pressure
_____Stomach or GI Problems/Food Allegies
_____Thyroid Problems
_____Cancer
_____High Cholesterol
_____Stroke
_____Organ Removal

Do you have any other medical conditions not mentioned above? _____No _____Yes
(If yes, please explain:_____
_____
_____

Please list any medications that you are taking:

Name	**Doseage**	**Reason**	**Frequency**

Are you taking a multi-vitamin and/or any other supplement(s)?

Name	**Dosage**	**Reason**	**Frequency**

Do you smoke? _____No _____Yes Cigarettes/day_____ Cigars/day___

Do you drink alcoholic beverages? _____No _____Yes If yes, how many drinks per week?
_____ (Note: one drink equals 1.5oz of hard liquor, 4-5oz of wine, or 12 oz. beer)

Which best describes the amount and type of stress you experience on a daily basis:
_____ Low stress _____ Occasional mild stress _____ Frequent mild stress
_____ Frequent moderate stress _____ Frequent high stress
_____ Constant Stress
Do you have any sleep disorders? _____No _____Yes
If yes, please explain_____
_____
_____
_____
_____

Part III. Weight History
Have you gained or lost weight in the past year? _____No _____Yes
If yes, please indicate the amount of weight change:
_____ Pounds Lost _____ Pounds Gained
What do you think is a realistic weight for you? _____

What happened between then and now to cause the weight change?
_____
_____
Have you ever followed a diet to lose weight? _____No _____ Yes
If yes, what has been your preferred method of dieting?
_____ Skip meals _____ Fasting (juicing, no food intake) _____ Restricting calories
_____ Restricting carbohydrates _____ Restricting fats _____ Reducing portions sizes
_____ Go on fad diets (e.g., Atkins, Zone) _____ Other:
_____

What challenges do you foresee preventing your success? (time constraints, discipline, lack of support, etc.)
_____
_____
Do you have support from family and friends? _____No _____Yes

Part IV. Diet History
Are you now, or have you ever been, on a special diet? _____No _____Yes (e.g., low calorie, diabetic, low sodium, low fat, low cholesterol, high fiber, vegetarian)
If yes, please describe:_____(Self or M.D. Prescribed)
Do you have any known food sensitivity or food allergies? _____No _____Yes
If yes, which foods_____
_____
_____

Do you consume fast food? _____No _____Yes (times per week _____)
If yes, where do you go and what do you currently order off the menu?

_____
_____
_____ _____

Do you eat out at Restaurants? _____No _____Yes (times per week_____)
If yes, where do you go and what do you typically order off of the menu?

_____
_____
_____

Where do you shop for groceries?

_____
_____

What are your favorite foods? What foods do you crave?

_____
_____
_____

Do you find yourself eating when: (check all that apply)
_____ Bored _____ Late at night _____ Increased stress _____ Anxiety
_____ Depressed _____ Constantly hungry

Part V. Exercise History

Do you have any physical problems that cause you to limit your physical activity?
_____ No_____Yes
(If yes, please explain)_____

_____
_____
_____

Workout Routine: Please provide the time of day you exercise, the type of exercise (e.g., cardio, strength training, yoga, stretching, etc.), and how you exercise. (Please be specific as this will directly affect your meal plan).

Day	**Time**	**Type**	**Duration**
Sunday			
Monday			
Tuesday			
Wednesday			
Thursday			
Friday			
Saturday			

Additional Comments below:

Please Sign Below:

Date: