Erin Livers, B.A., I.C.N.T.

Food As Nourishment Holistic Health Counseling
4150 Darley Ave, Suite #6, Boulder, CO 80305 • (303) 499-6059

I am a Nutrition Therapist & Holistic Health Educator. I'm certified as an Integrated Clinical Nutrition Therapist and Board Certified in Holistic Nutrition (Honorary). As such, I am NOT A PHYSICIAN, meaning I do not diagnose or treat disease, rather I help support the innate healing response of the body through food, nutrition supplements, and lifestyle recommendations. I have worked in this field since 2004.

Consent for Treatment & Policy Agreement

Fees $250 for 2-hour consultation
$250 for 1-hour LEAP consultation (incl. 2 hours prep)
$190 for NEW CLIENT 90-minute consultation
$125 per hour for subsequent consults (office, phone or Skype)
$65 for half-hour consults (office, phone or Skype)
$32 for 15-minute phone consult

All payments are due when services are rendered. Cash, check and credit cards are accepted. **Credit card payments can be made to** PayPal.me/ErinLivers**. Please make all checks payable to Erin Livers.** Supplements are not included in the consultation fees, and supplement prices are subject to change.

Cancellation Policy
Scheduled appointments that are missed or not canceled with at least 24 hours notice will be charged at the regular hourly rate. Also, if you are more than 20 minutes late, the appointment will be rescheduled for a later date and the full price of the session will be charged. Emergency situations are exceptions to this policy.

Communication outside of Scheduled Appointments Policy
Email communication is preferred, so please send questions that can be answered in 5 minutes or less to foodasnourishment@comcast.net Erin will respond within 48 hours. Erin will get your approval to track email time spent beyond 5 minutes if possible/requested. For questions too complex for email, please call the number above to make an office or phone appointment. Erin charges for time used based on $125/hour. If your request is urgent, please indicate that in the email or call the office to leave a message You are encouraged to call 911 if you have a medical emergency.

Please sign and date below to indicate that you have been advised of these policies.
I have been advised and fully understand that as a Nutrition Therapist, Erin Livers is not a medical doctor and does not diagnose or treat medical conditions nor prescribe controlled substances. I understand that Nutrition Therapy is not a substitute for Western Medicine and I am not seeking a medical opinion. I further understand that I am free to seek medical advice and treatment at any time.

_____ _____
Print name Date

_____
Signature

For instructions on how to fill out these forms online using Adobe Acrobat, so you can email them to Erin, go here: https://helpx.adobe.com/acrobat/using/filling-pdf-forms.html. From this web page, scroll down to ***Fill in flat forms with the Fill & Sign tools*** *OR from Adobe Acrobat click on the link with the same name to the right.*

Erin Livers, ICNT
Nutrition Therapist

New Client Form

Date_____Medical/Allergy Alerts_____

Name_____Date of Birth_____Age_____

Full Name given at birth_____Cultural Heritage_____

Address_____

Email_____

Home Phone_____Work/Cell Phone_____

Occupation_____Employer_____

Physician/Phone_____Date of last visit_____

Emergency Contact/Phone_____Referred by_____

What is the reason for your visit?

List your top 5 health concerns in order of importance.

_____

_____

_____

_____

_____

How would you describe your health?

Briefly state your relationship to the following, including any issues, concerns and/or successes.

Eating_____

_____

Sleeping_____

Social Life_____

Creative Projects/Hobbies_____

Exercise/Activity_____

Spiritual Practices_____

Family_____

Career_____

Cooking_____

Do you cook? Yes No If no, who?_____

Do you grocery shop? Yes No If no, who?_____

Do you read food labels? Yes No How many meals do you eat out per week?_____

Do you currently follow a special diet or nutritional program? Yes No If yes:

Check all that apply:

☐ Low Fat ☐ Low Carb ☐ High Protein ☐ Low Sodium

☐ Diabetic/Low sugar ☐ Vegetarian/Vegan ☐ Weight Loss ☐ Paleo

☐ Other_____

Diagnosed food allergies/sensitivities? Yes No If yes, list food(s)_____

Any foods cause indigestion/symptoms? Yes No If yes, list food(s)_____

Any foods you couldn't live without? Yes No If yes, list food(s)_____

Do you avoid any particular foods? Yes No If yes, foods/reason_____

_____

Alcoholic drinks/week_____Caffeinated drinks/day_____Sodas/day_____Diet sodas/day_____

Any immediate relatives diagnosed with Ulcerative Colitis, Crohn's Disease, Celiac Disease or IBS? Yes No

If yes, list_____

Height (feet/inches)_____Current Weight_____Desired Weight_____Body Fat %_____

How often do you weigh yourself? Daily Weekly Monthly Rarely Never

Do you believe stress is presently reducing the quality of your life? Yes No

Rate your stress (1-10) during avg. week

Work_____Family_____Social_____Financial_____Health_____Other_____

What is your preferred method(s) of relieving stress/relaxation?_____

_____

Do you like the work you do? Yes No

Do you have trouble falling asleep? Yes No Problems w/ insomnia? Yes No Avg hrs sleep/night_____

Check all factors that apply to your current lifestyle and eating habits:

- Fast eater
- Erratic eating pattern
- Eat too much
- Late night eating
- You or family dislikes healthy food
- Time constraints
- Love to eat
- Travel frequently
- Do not plan meals or menus
- Reliance on convenience items
- Smoke Amount per day_____
- You or family has special dietary needs or preferences
- Eat more than 50% meals away from home
- Eat only because I have to
- Eat when sad, lonely, depressed, bored
- Eat too much under stress
- Eat too little under stress
- Don't like to cook
- Eat in the middle of the night
- Confused about nutrition advice
- Poor snack choices

Anything else you want me to know?

_____

_____

List all medications, both prescription and over-the-counter.

Medication	Dose	Frequency	Start Date (mo/year)	Reason for Use

List all nutrition supplements, vitamins, herbs, etc.

Supplement & Brand	Dose	Frequency	Start Date (mo/year)	Reason for Use

Have your medications or supplements ever caused you unusual side effects or problems? Yes No

Prolonged or regular use of NSAIDS (Advil, Aleve, Motrin, Aspirin)? Yes No

Prolonged or regular use of Acid Blocking Drugs (Tagamet, Zantac, Nexium, Prilosec, etc.) Yes No

Frequent antibiotics (>3x/year)? Yes No Long term antibiotics? Yes No

Use of steroids (prednisone, nasal allergy inhalers) currently or in the past? Yes No

List hospitalizations, include dental surgeries and serious injuries/broken bones.

Date	Reason

Health History

Blood type: ☐ A ☐ B ☐ O ☐ AB ☐ Rh negative

Check any conditions you have or have had in the past.

☐ Chicken Pox	☐ Anxiety	☐ Headaches	☐ Mental condition	☐ Depression
☐ Seasonal allergies	☐ Asthma	☐ Tuberculosis	☐ Pneumonia	☐ Tonsilitis
☐ Parasites/Giardia	☐ Arthritis	☐ Urinary Tract Infections	☐ Interstitial Cystitis	☐ Hemorrhoids
☐ Eating disorder	☐ Hiatal Hernia	☐ Eczema	☐ Psoriasis	☐ Gall Stones
☐ Hepatitis	☐ Gout	☐ Kidney Infect/Stone	☐ Alcoholism	☐ Drug Addiction
☐ Hypo/Hyperthyroid	☐ Frequent Colds/Flu	☐ Macular Degeneration	☐ Glaucoma	☐ Candidia (Yeast)
☐ IBS/IBD	☐ Crohn's Disease	☐ Weight Loss or Gain	☐ GERD	☐ Ulcer
☐ Heart Disease	☐ High Blood Pressure	☐ Diabetes Type I or II	☐ Hypoglycemia	☐ Celiac Disease

☐ Any AutoImmune Condition_____

☐ Cancer_____

☐ **Dental Problems:** ☐ Mercury Amalgams ☐ Root Canals #_____ ☐ Bleeding Gums ☐ Gum Disease

Digestion

How many bowel movements do you have? Daily_____Weekly_____

Do you experience Diarrhea? Yes No Constipation? Yes No Both? Yes No

Toxicity

Have you ever had an exposure to pesticides, chemicals or heavy metals? Yes No

Do you regularly spray your house or lawn with insecticides/pesticides/herbicides? Yes No

Menstrual History *(women only)*

Age at first period_____Menses Frequency_____Length_____Pain? Yes No Clotting? Yes No

Ever skipped your period? Yes No For how long?_____

Check all that apply. ☐ PMS ☐ Heavy Periods ☐ PCOS ☐ Abnormal PAP

☐ Fibrocystic breasts ☐ Endometriosis ☐ Facial hair growth ☐ Fibroids ☐ Infertility

☐ Increased libido ☐ Decreased libido (sex drive)

Hormonal contraceptives? Yes No For how long?_____Type?_____

Pregnancies_____Date of last PAP/result_____

Are you in menopause? Yes No Age at menopause_____Years in menopause_____

Check all that apply. ☐ Hot flashes ☐ Mood swings ☐ Weight Gain ☐ Incontinence

☐ Concentration/Memory Problems ☐ Vaginal Dryness ☐ Decreased libido ☐ Depression

Use of hormone therapy. Yes No How long?_____

Date of last Mammogram/result_____

Men's History *(men only)*

☐ Live alone ☐ Live with family ☐ Live with spouse/partner

Have you had a PSA test? Yes No PSA Level: ☐ 0-2 ☐ 2-4 ☐ 4-10 ☐ >10

Check all that apply. ☐ Muscle Soreness ☐ Mood swings ☐ Weight Gain esp waist/hips ☐ Mental fatigue

☐ More emotional than in the past ☐ Depression ☐ Decreased physical stamina ☐ Decreased libido

☐ Decrease in spontaneous erections ☐ Decrease in fullness of erections ☐ Sweating attacks

☐ Urination difficulty or dribbling ☐ Frequent Urination ☐ Leg nervousness at night

Food As Nourishment

Symptom Survey

INSTRUCTIONS:

NOTE:You will be asked to take this Symptom Survey twice, maybe more times WITHOUT looking at your previous scores. You can download this form from the Client Log-in area of Erin's website at any time. Click here: http://foodasnourishment.com, select the Client Log-in Tab at the top and enter the password: ***grateful*** *You will find many free resources there for clients.*

Fill out the following survey by scoring every symptom based on your experience over the last 30 days using the scale of symptom points listed below. Mark an **X** or ✔ over or circle the appropriate score in the corresponding field for every symptom listed (as shown in the example), then total each section. After totaling each section, add all the numbers together to get your final score. If you add a symptom at the end, indicate which group it goes in and add its total to that group. For example, SNORING (NASAL/SINUS).

After making your calculations on the next page, don't forget to fill in your NAME and your FINAL SCORE at the bottom of this page before emailing.

Use the ***Fill & Sign Tools*** *from Adobe Acrobat to fill this out online and email it OR you can print it, fill it out on paper, scan it or photograph it and email or mail it via USPS.*

Scale of Symptom Points

0 = Never or almost ever experience this symptom
1 = Experienced Occasionally (less than 2x/week), symptom wasn't severe
2 = Experienced Frequently (2 or more times per week), symptom wasn't severe
3 = Experienced Occasionally and symptom was severe
4 = Experienced Frequently and symptom was severe

EXAMPLE:

CONSTITUTIONAL	NASAL/SINUS	MUSCULOSKELETAL
0 1 2 3 **X** Fatigue (sluggish, tired)	0 1 2 3 ✔ Allergies	0 **(1)** 2 3 4 Joint Pains, Aching
X 1 2 3 4 Restless (can't relax)	0 1 ✔ 3 4 Sinus Pain	0 1 **(2)** 3 4 Stiff Joints
0 1 **X** 3 4 Sleepiness During Day	✔ 1 2 3 4 Runny Nose, Nasal Drip	0 **(1)** 2 3 4 Muscle Aches, Cramps
X 1 2 3 4 Insomnia at Night	0 1 2 3 ✔ Stuffy Nose	0 1 2 **(3)** 4 Stiff Muscles
0 1 2 3 **X** Feel Cold	0 1 ✔ 3 4 Sneezing	**(0)** 1 2 3 4 Swelling
10 **Total**	✔ 1 2 3 4 Sinus Infection	**7** **Total**
	12 **Total**	

Symptom Survey is on the next page (scroll down).

Symptom Survey

CONSTITUTIONAL	NASAL/SINUS	MUSCULOSKELETAL
0 1 2 3 4 Fatigue (sluggish, tired)	0 1 2 3 4 Allergies	0 1 2 3 4 Joint Pains, Aching
0 1 2 3 4 Restless (can't relax)	0 1 2 3 4 Sinus Pain	0 1 2 3 4 Stiff Joints
0 1 2 3 4 Sleepiness During Day	0 1 2 3 4 Runny Nose, Nasal Drip	0 1 2 3 4 Muscle Aches, Cramps
0 1 2 3 4 Insomnia at Night	0 1 2 3 4 Stuffy Nose	0 1 2 3 4 Stiff Muscles
0 1 2 3 4 Feel Cold	0 1 2 3 4 Sneezing	0 1 2 3 4 Swelling
_____ **Total**	0 1 2 3 4 Sinus Infection	_____ **Total**
EMOTIONAL/MENTAL	_____ **Total**	**CARDIOVASCULAR**
0 1 2 3 4 Mood Swings	**MOUTH/THROAT**	0 1 2 3 4 Irregular Heartbeat
0 1 2 3 4 Depression	0 1 2 3 4 Cough	0 1 2 3 4 High Blood Pressure
0 1 2 3 4 Anxiety, Fears	0 1 2 3 4 Sore or Swollen Throat	_____ **Total**
0 1 2 3 4 Anger, Irritability	0 1 2 3 4 Swelling of Lips/Tongue	**DIGESTIVE**
0 1 2 3 4 Poor Memory	0 1 2 3 4 Gagging, Throat Clearing	0 1 2 3 4 Heartburn, Reflux
0 1 2 3 4 Lack of Focus/Concentration	0 1 2 3 4 Canker Sores	0 1 2 3 4 Belching
_____ **Total**	_____ **Total**	0 1 2 3 4 Stomach Pains, Cramps
HEAD/EARS	**LUNGS**	0 1 2 3 4 Intestinal Pains, Cramps
0 1 2 3 4 Migraine (any kind)	0 1 2 3 4 Wheezing	0 1 2 3 4 Constipation
0 1 2 3 4 Headache (not Migraine)	0 1 2 3 4 Chest Congestion	0 1 2 3 4 Diarrhea
0 1 2 3 4 Dizziness	0 1 2 3 4 Dry Cough	0 1 2 3 4 Bloating Sensation
0 1 2 3 4 Earache, Infection	0 1 2 3 4 Wet Cough	0 1 2 3 4 Gas (of any kind)
0 1 2 3 4 Ringing in Ear	_____ **Total**	0 1 2 3 4 Nausea, Vomiting
0 1 2 3 4 Itchy Ears	**EYES**	0 1 2 3 4 Light-colored Stools
_____ **Total**	0 1 2 3 4 Red or Swollen Eyes	_____ **Total**
SKIN	0 1 2 3 4 Watery or Itchy Eyes	**WEIGHT MANAGEMENT**
0 1 2 3 4 Blemishes, Acne	0 1 2 3 4 Blurred Vision	0 1 2 3 4 Food Cravings
0 1 2 3 4 Rashes, Hives	0 1 2 3 4 Dark Circles or Bags	0 1 2 3 4 Binge Eating/Drinking
0 1 2 3 4 Eczema	_____ **Total**	0 1 2 3 4 Purging (Any)
0 1 2 3 4 Rosy Cheeks	**GENITOURINARY**	_____ **Total**
0 1 2 3 4 Hair Loss	0 1 2 3 4 Increased Urinary Frequency	0 1 2 3 4 Other_____
0 1 2 3 4 Flushing, Excess Sweating	0 1 2 3 4 Painful Urination	0 1 2 3 4 Other_____
_____ **Total**	_____ **Total**	0 1 2 3 4 Other_____

NAME_____ **FINAL SCORE**_____

Food As Nourishment

Diet Log

NOTE: You may be asked to fill out another Diet Log during your work with Erin. You can download this form from the Client Log-in area of her website at any time. Click here: http://foodasnourishment.com, select the Client Log-in Tab at the top and enter the password: ***grateful*** *You will find many free resources there for clients.*

INSTRUCTIONS:

Log what you eat for several days up to one week using the form that follows on the next two pages. Start by indicating the date and the time you get up. You'll log how you're feeling before and after each meal, as well as the time of your meals and snacks. You will be prompted to describe your meals, your portions, the meal's setting and how satisfied you are with the meal on a scale of 1-10. There is a also space to log snacks, exercise and any comments.

How do you feel? Don't use words that reveal little such as: good, OK, excellent, or even tired, hungry or upset. If you're tracking a symptom, such as joint pain, headache, or heartburn then you can use this area to track that symptom. If you're answering generally, then use descriptive information about your emotional or physical state, hunger/appetite, and circumstances, such as:
Before meals: depressed, don't know what to make/eat, lightheaded, rushed, brain fog, etc.
After meals: bloated, X hurts, stressed, still hungry, craving X, grounded, energetic, etc.
Example: If you're tracking hunger, energy or mood instead of writing hungry, tired or down, use hunger + numbers on a scale of 1-10 or use more descriptive language: no appetite, too full, very hungry, famished, or feeling faint. Do the same with energy or mood.

At mealtimes. Describe the meal as completely as possible including all foods and beverages and estimate quantities/portions of foods as accurately as you can. If you can estimate based on cups and teaspoons/tablespoons, use that. If not, describe as 1 potato, 2 cookies, and as small, medium or large servings. If you can't describe your quantities, then only indicate when it's not a "normal" serving size, such as very small: 3 raisins, 2 almonds OR very large: 15 cookies, a container of ice cream.

At mealtimes. Indicate the meal's setting such as: kitchen table, LR couch, my desk, or in the car. Score the meal on a scale of 1-10 in regard to how satisfied you feel. You may eat a delicious meal, but an argument with your spouse or a challenging setting like your work desk may reduce your satisfaction with the meal to a lower number. Score the food, but also your feelings about the meal and how nourishing it is for you.

New clients: Do your best to include a diet log for the full 7 days, but if you can fill it out for 3 days, that's usually fine. If the 3 days you choose to log are particularly unusual (vacation, for example), then it may not be helpful to do it. If you don't fill out a diet log for any reason, we can work around this.

Use the ***Fill & Sign Tools*** *from Adobe Acrobat to fill this out online and email it OR you can print it, fill it out on paper, scan it or photograph it and email or mail it via USPS.*

Daily Diet Log

	MONDAY	TUESDAY	WEDNESDAY
Date /Time Up			
How do you feel?			
Bfast Time			
How do you feel?			
BREAKFAST -Meal -Portion -Setting -Satiety 1-10			
How do you feel?			
Lunch Time			
How do you feel?			
LUNCH -Meal -Portion -Setting -Satiety 1-10			
How do you feel?			
Dinner Time			
How do you feel?			
DINNER -Meal -Portion -Setting -Satiety 1-10			
How do you feel?			
BedTime			
Snacks			
Exercise / Daily Practice			
General Comments			

Daily Diet Log

	THURSDAY	FRIDAY	SATURDAY	SUNDAY
Date /Time Up				
How do you feel?				
Bfast Time				
How do you feel?				
BREAKFAST -Meal -Portion -Setting -Satiety 1-10				
How do you feel?				
Lunch Time				
How do you feel?				
LUNCH -Meal -Portion -Setting -Satiety 1-10				
How do you feel?				
Dinner Time				
How do you feel?				
DINNER -Meal -Portion -Setting -Satiety 1-10				
How do you feel?				
BedTime				
Snacks				
Exercise / Daily Practice				
General Comments				