Francesca Alfano Nutrition

www.francescaalfano.com

NUTRITION INFORMED CONSENT

Services to Be Provided

Francesca Alfano's goal is to help you achieve the highest state of health consistent with your own goals. Nutrition can serve as an excellent adjunct to a medical doctor's treatment, but are not a substitute for that treatment. Services offered as a part of this consultation may include education about nutrition, personalized whole foods and dietary recommendations, meal plans, lifestyle modifications, herbs and nutritional supplement recommendations, such as but not limited to vitamins, minerals, herbs, amino acids

and fatty acids. As a part of Medical Nutrition Therapy, Francesca Alfano will perform a comprehensive nutrition assessment determining a nutrition diagnosis; plan and implement a nutrition intervention; and monitor and evaluate your progress.

Notice of Privacy Practices

All patient information is handled under the HIPAA Privacy Act. The privacy of your medical information, as described in the HIPAA Privacy Act, is important to Francesca Alfano. As a client of Francesca Alfano, a record of your care and services will be created. This record is required to provide you with quality care and to comply with certain legal requirements. Francesca Alfano will not use or disclose your medical information for any purpose, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to Francesca Alfano at the address below. Francesca Alfano may use medical information about you to provide you with medical treatment or services and may disclose medical information about you to doctors, nurses, or other health care providers to assist them in treating you.

Client Rights and Responsibilities

It is your responsibility to fully disclose health information to Francesca Alfano. As service progresses, inform your practitioner of changes that occur, including medication and health changes. You have the right to respectful, courteous care and can refuse to follow any or all recommendations provided as a result of this consultation. You have the right to choose another practitioner for any reason and to request that health information be disclosed to another practitioner or health care provider.

Fees and Charges

Payment for the consultation is due at the time services are rendered. Except in emergency situations, you will be charged for missed appointments without 24 hours notice. The fee for missed appointments is the cost of the visit.

Supplement Safety

The historical record and modern research indicate that herbs and supplements most often used for healthcare have a good safety record. Similarly, confirmed cases of herb, nutrient and drug interactions are rare. However, adverse events can occur after using any active substance, including allergic response. Therefore it is imperative that you disclose to your practitioner: 1) all medications, supplements and herbs currently in use, 2) any liver or kidney disease (past or present), 3) any allergies, 4) if you plan to become pregnant or are currently pregnant or breastfeeding. It is important to stay within the dosage recommended. You are expected to inform your physicians of any nutritional supplement or herb use. Any suggestion that the effect of a drug is being altered by simultaneous use of an herb or nutritional supplement should be reported directly to all health professionals involved. It is also advisable to stop taking herbs and supplements 7 days before and after a surgical operation, and/or in the event of being prescribed a new medication.

Informed Consent

I am solely responsible for the decision to see Francesca Alfano for Nutrition Counseling. I have reviewed this document, including safety of supplements, services to be provided, cancellation fees, my responsibilities as a client, and the Notice of Privacy Practices. I understand Francesca Alfano is not a physician and therefore cannot diagnose or treat disease, or prescribe drugs. If I have not already done so, I agree to consult a medical doctor for any serious or life-threatening disease conditions, either for myself or someone under my guardianship. I have had the opportunity to ask the practitioner questions regarding the proposed services, this consent form, and other pertinent information and have received satisfactory explanations. I understand that I am free to discontinue service(s) at any time.

Client's Name: _____

Client Signature: _____
Date: _____

Parent or Guardian Signature

(if client is under 18 years old): _____
Date: _____

Witness/Practitioner Signature: _____
Date: _____

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Nutrition and Integrative Health Pediatric Questionnaire

Instructions

Required for your child's first visit:

1. The completed new client questionnaire, along with the 3-Day Diet Diary included in the questionnaire.

   Instructions for completing the 3-Day Diet Diary:

   - Record information as soon as possible after the food has been consumed. Please include all beverages, even water.
   - Do not change your eating behavior at this time unless your doctor advises you to. The purpose of this food record is to analyze your present eating habits.
   - Describe the food or beverage consumed. e.g., milk - what kind? (whole, 2%, or nonfat); toast - (whole wheat, white, buttered); chicken - (fried, baked, breaded), etc.
   - Record the amount of each food consumed using standard measurements as much as possible, such as 8 ounces, 1/2 cup, 1 teaspoon, etc.
   - Include any additional items (i.e. condiments). For example: tea with 1 teaspoon sugar, potato with 2 teaspoons butter, etc.

2. Please send your student prior to your visit any labs, blood tests or other pertinent medical information you think may be helpful for this case study.

If you have any questions please contact Francesca Alfano.

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Pediatric Questionnaire

Client confidentiality will be maintained at all times. The information provided on this questionnaire may only be disclosed with the express written consent of the individual named herein or, if under the age of 18, his or her legal guardian.

Please allow 30-45 minutes to complete most of this questionnaire. The 3-day diet diary will require you to record your food and beverage intake over a 3-day period. Please answer the questions below as thoroughly as possible so that we may make the best possible clinical assessment. This helps us develop a realistic and workable plan for supporting you in reaching your health goals. Your answers to personal questions such as relationship status, religion, etc. are important as they provide helpful context for establishing a productive partnership with you. That said; please answer only the questions you are comfortable answering.

Basic Information

School & Interests											
Grade:		What are your interests/passions?									
Demographics											
Child's Age		DOB		Gender		Race		Ethnicity			
Birth Length:		Birth Weight:	lbs.	Current Height:		Current Weight:		lbs. / Yr.:			
Childcare Arrangements (if any) Hours, Caregivers											
At Home		Group Setting				School Setting					
Personal Information											
Religion:		Education:									
With whom (persons or animals) do you share your home?											

What types of health practitioners are you currently working with?

What are your primary reasons for coming to see Francesca?

1.

2.

3.

Medical Information

What health concerns has your child experienced?

Has your child been diagnosed by their doctor with a medical condition (s)? If so, please list:

Does your child have any allergies to foods, medications, chemicals, and/or other environmental substances?

If so, to which ones?

What is your child's typical reaction and how severe is it (1-10)?

Any surgeries/operations/hospitalizations and when?

Has your child ever had a major chemical exposure? If so, when and to what?

Do you follow a modified immunization schedule?
Please provide any relevant details:

Where and when has your child lived or traveled outside of the U.S. and Canada?

Is there anything that surfaced during a recent medical test, lab work, or doctor's visit that you would like to report?

Was your child breastfed or formula fed?

Was your child born vaginally or cesarean?

Medications & Supplements

Past and Current Medications (Over-the-Counter and Prescription)				
Name	Dosage	Frequency	Length of Time	Reason for Taking
Are you sensitive to low levels of medication(s)?				

Current Dietary or Herbal Supplements					
Name	Brand	Dosage	Frequency	Length of Time	Reason for Taking

Family History

Relationship	Alive/Deceased	Present Health or Cause of Death
Paternal Grandmother		
Paternal Grandfather		
Maternal Grandmother		
Maternal Grandfather		
Father		
Mother		
Brothers		
Sisters		

Lifestyle

PHYSICAL ACTIVITY	
How much time does your child spend playing outdoors?	
What extracurricular activities is your child involved in?	
How many hours of TV per day?	
How many hours of video, computer, or similar games does your child play per day?	
How many hours does your child spend on homework or schoolwork each day?	

SLEEP/NAPS	
At what time is your child typically in bed?	
Does your child share sleep space?	
Does your child have difficulty falling asleep?	
Typical hours of nighttime sleep?	
# of times your child awakens during the night	
Reason(s) why your child wakes during the night	
Does your child feel rested upon rising?	
Does your child have nightmares?	
Describe evening/bedtime routine:	

Review of Body Systems:

Please place an **"X"** next to anything your child is currently experiencing. Issues that your child has had previously, but no longer has, mark with a **"P."** Also provide answers to those items marked with a question mark.

Head
- [ ] seizure
- [ ] headache
- [ ] migraines

Eyes/Ears/Nose
- [ ] vision loss
- [ ] eye discharge
- [ ] eye redness
- [ ] ear/eye infection
- [ ] corrective lenses
- [ ] hearing loss
- [ ] ringing the ears
- [ ] ear discharge/itching
- [ ] pain
- [ ] nosebleed
- [ ] nasal congestion

Neck and Throat
- [ ] pain
- [ ] lump
- [ ] stiffness
- [ ] tonsillitis

Lymph Nodes
- [ ] congestion
- [ ] swollen
- [ ] painful

Allergic & Immunologic
- [ ] respiratory allergies
- [ ] immune disorder
- [ ] frequent colds or flu
- [ ] food allergies
- [ ] food sensitivities
- [ ] asthma

Female Reproductive

Date of last menses

Length of menses days
- [ ] painful cramps
- [ ] bleeding between cycles
- [ ] not menstruating
- [ ] fibroids
- [ ] endometriosis
- [ ] PCOS

Urinary

Urinations a day?

Color of urine?
- [ ] urinary tract infection
- [ ] bedwetting
- [ ] pain on urination
- [ ] blood in urine
- [ ] dark circles under eyes

Neuropsychiatric
- [ ] acts up in school
- [ ] irritable
- [ ] difficulty concentrating
- [ ] withdrawn
- [ ] short tempered
- [ ] prefers to be with others
- [ ] prefers to be alone
- [ ] hyperactive
- [ ] difficulty getting along with friends and family

Gastrointestinal
- [ ] bad breath
- [ ] ulcers
- [ ] bloating/gas
- [ ] pain/cramping
- [ ] nausea
- [ ] acid reflux/GERD
- [ ] tends to constipation
- [ ] variable bowel habits
- [ ] tends to diarrhea
- [ ] undigested food in stools
- [ ] blood in stools
- [ ] picky eater
- [ ] difficulty gaining weight
- [ ] difficulty loosing weight

Bowel movements

per day? OR # per week?

Quality?
- [ ] pebbly
- [ ] fully formed
- [ ] soft & largely unformed
- [ ] loose and unformed

Skin
- [ ] rash
- [ ] dry skin
- [ ] itching
- [ ] acne
- [ ] bruise easily
- [ ] nail problems
- [ ] hair quality changes
- [ ] slow wound healing

Musculoskeletal
- [ ] muscle pain
- [ ] arthritis / joint pain
- [ ] stiffness
- [ ] back ache/pain
- [ ] mobility restrictions

Respiratory
- [ ] congestion
- [ ] sinus pain/inflammation
- [ ] difficulty breathing
- [ ] cough
- [ ] asthma

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Food/Drink	Frequency				Comments
	Monthly	Weekly	Daily	Multiple times a day	
Caffeine					In what form?
Soda/Soft Drinks					What type(s)?
Alcohol					What type(s)?
Herb tea					What type(s)?
Red Meat					Beef, Lamb, Sausage/deli
White Meat					Poultry, Pork Sausage/deli
Eggs					
Fish/Shellfish					
Nuts & Seeds					
Fruits					Canned, Fresh, Frozen
Vegetables					Canned, Fresh, Frozen
Lentils & Beans					Canned, Fresh, Frozen
Oils / fats (e.g., olive, butter)					What type(s)?
Dairy Products					Milk, Yogurt, Cheese, Butter
Soy Products					What type(s)?
Whole grains					What type(s)?
Grain-based products					Bread, Pasta, Crackers
”Junk / Fast Food”					What type(s)?
Fried Foods					What type(s)?
How many times each week does your child eat each meal at home (vs. out)?					Breakfast, Lunch, Dinner
Approximately how many **ounces** of water does your child drink per day?					oz Bottled, Filtered, Tap
Where do you grocery shop?					

Nutrition - 3-Day Food Diary Record information as soon as possible after the food has been consumed. Please include all beverages, even water.		
Day 1	Day 2	Day 3
Breakfast	Breakfast	Breakfast
Snack	Snack	Snack
Lunch	Lunch	Lunch
Snack	Snack	Snack
Dinner	Dinner	Dinner
Snack	Snack	Snack

Moods Your Child Experiences Frequently

☐ accepting	☐ anxious or nervous	☐ angry	☐ capable	☐ compassionate
☐ determined	☐ dreadful	☐ empowered	☐ enthusiastic	☐ fortunate
☐ guilty	☐ happy	☐ hopeful	☐ hurt	☐ inspired
☐ lonely	☐ loved	☐ peaceful	☐ resentful	☐ resigned
☐ sad	☐ scared	☐ terrified	☐ tired	☐ uncertain

other:

Significant Life Events

Please list major events in the last ten years of your life and the dates they occurred. Include births, deaths, marriage, divorce, accidents, moves, jobs changes, miscarriages, illness, and anything else you feel greatly impacted your or your child's life.

Date	Event

Thank you for taking the time to complete this questionnaire.