Nourish Your Whole Self.

Welcome!

I am so glad you are here. You've made a courageous and empowered decision to create a better relationship to food and your body. This is a brave step in the process of improving your life and nourishing all parts of yourself – mind, body and spirit.

Nutrition therapy not only involves addressing what you eat, but also how you think and feel about food and your body, and how that is reflected in other areas of your life. Throughout our time together, I will strive to understand your needs, preferences and goals, in order to offer personalized and compassionate support on your journey to food and body peace. I hope to create a relationship built on trust, so that we can honestly and openly communicate with one another. Please visit my website at www.thewholeyogiRD.com for more information about my background, education and philosophy.

As human beings, making changes that will last a lifetime occurs in stages and often takes time, because our habits are deeply engrained. Be patient and trust in the process. You may be wondering how many times we'll need to meet. That entirely depends on the purpose of our meeting, your goals, your readiness to change, what support systems you have in place, your current self-care practices and several other factors. For starters, here's some of what you can expect:

Initial Session: 60-75 minutes

Lifestyle and nutrition assessment, baseline goal setting and development of nutrition and self-care plan, based on your needs.

Please bring the following items to your first appointment*.

1.) **The Foundation Packet (you're reading it!)**
   - Signed copy of the Privacy Agreement - page 6 of this packet
   - Signed copy of the Payment & Cancellation Agreement - page 7 of this packet
   - New Client Registration Page - Page 8 of this packet

2.) **OPTIONAL:**
   - **Nutrition Consultation Questionnaire -** pages 9-17 of this packet.
   - **Food Journals:** a blank food journal can be found on the "Therapists" page of the Marietta Counseling for Children & Adults website if you wish to fill it out before we meet. However, if you are not currently logging your food, you do not need to begin. If you are, feel free to use your current system.

Do your best to have the information listed above filled out for our first session. If you become overwhelmed, have trouble or don't feel comfortable answering any of the questions, leave it blank! If there is additional info you'd like to include, please feel free to do so.

Subsequent Sessions: 45-60 minutes

During our follow-up sessions, we will continue to talk through your personal goals, revise our care plan as needed, talk through medical labs if necessary, identify additional resources that might be helpful to you (i.e. books, hand-outs, podcasts, meditations, yoga & breathing techniques, other self-care tools, referral to see a mental health professional, etc.). The decision to continue meeting will be a shared one but ultimately you will decide what is most helpful for you.

I look forward to meeting you and welcome any and all questions you might have.

Sincerely,

Caroline

Caroline L. Young, MS, RD, LD, RYT

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions about this Notice, please contact your provider, Caroline L. Young, MS, RD, LD, RYT (LLC).

MY PLEDGE REGARDING PROTECTED HEALTH INFORMATION:

I understand that protected health information about you and your health is personal. I am committed to protecting health information about you. This Notice applies to all of the records of your care generated by me. This Notice will tell you about the ways in which I may use and disclose protected health information about you. It also describes your rights and certain obligations I have regarding the use and disclosure of protected health information.

The law requires me to:

- make sure that protected health information that identifies you is kept private;
- notify you about how I protect protected health information about you;
- explain how, when, and why I use and disclose protected health information;
- follow the terms of the Notice that is currently in effect.

I am required to follow the procedures in this Notice. I reserve the right to change the terms of this Notice and to make new Notice provisions effective for all protected health information that I maintain by:

- posting the revised Notice in my office and
- making copies of the revised Notice available upon request.

HOW I MAY USE AND DISCLOSE PROTECTED HEALTH INFORMATION ABOUT YOU.

The following categories describe different ways that I may use and disclose protected health information about you without your written authorization.

- **For Treatment.** I may use and disclose protected health information about you to provide you with, coordinate, or manage your medical treatment or services. Specifically, I may share protected health information about you to the physician, therapist, or other health professional or agency that referred you to me, as part of my effort to coordinate your follow up care. I may also share protected health information about you in order to coordinate different things you need, such as prescriptions, lab work, or psychological services. I may disclose protected health information about you to people who provide services that are part of your medical care. And, I may use and disclose protected health information to contact you as a reminder that you have an appointment with me for medical nutrition therapy.
- **For Payment of Services.** I may use and disclose protected health information about you so that the treatment and services you receive from me may be billed to and payment may be collected from you, an insurance company, or a third party. For example, I may need to give your health plan information about the nutrition services you received so your health plan will pay me or reimburse you for the service. I may also tell your health plan about the nutrition services you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.
- **For Health Care Operations.** I may use and disclose protected health information about you for my health care operations, such as my quality assessment and improvement activities, case management, business planning, customer services, and other activities. These uses and disclosures are necessary to run my practice, reduce health care costs, and make sure that all of my clients receive quality care. For example, I may use protected health information during professional supervision to review my treatment and services and to evaluate my performance. I may also combine protected health information about many of my clients to decide what additional services I should offer, what services are not needed, and whether certain treatment approaches are effective. I may also disclose information to doctors, nurses, therapists, fitness professionals, or other dietitians for review and learning purposes. I will always remove

information that identifies you from this set of protected health information so others may use it to study health care and health care delivery without learning who the specific clients are.

- Subject to applicable state law, in some limited situations the law allows or requires us to use or disclose your protected health information for purposes beyond treatment, payment, and operations. However, some of the disclosures set forth below may never occur in my practice.
- **As Required by Law**. I will disclose protected health information about you when required to do so by federal, state, or local law.
- **Research**. I may disclose your protected health information to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information
- **Health Risks**. I may disclose protected health information about you to a government authority if I reasonably believe you are a victim of abuse, neglect, or domestic violence. I will only disclose this type of information to the extent required by law, if you agree to the disclosure, or if the disclosure is allowed by law and I believe it is necessary to prevent or lessen a serious and imminent threat to you or another person.
- **Judicial and Administrative Proceedings**. If you are involved in a lawsuit or dispute, I may disclose your information in response to a court or administrative order. I may also disclose health information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made, either by us or the requesting party, to tell you about the request or to obtain an order protecting the information requested.
- **Business Associates**. I may disclose information to business associates who perform services on my behalf (such as billing companies); however, I require them to appropriately safeguard your information.
- **Public Health**. As required by law, I may disclose your protected health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.
- **To Avert a Serious Threat to Health or Safety**. I may use and disclose protected health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.
- **Health Oversight Activities**. I may disclose protected health information to a health oversight agency for activities authorized by law. These activities include audits, investigations, and inspections, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.
- **Law Enforcement**. I may release protected health information as required by law, or in response to an order or warrant of a court, a subpoena, or an administrative request. I may also disclose protected health information in response to a request related to identification or location of an individual, victims of crime, decedents, or a crime on the premises.
- **Organ and Tissue Donation**. If you are an organ donor, I may release protected health information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.
- **Special Government Functions**. If you are a member of the armed forces, I may release protected health information about you if it relates to military and veteran’s activities. I may also release your protected health information for national security and intelligence purposes, protective services for the President, and medical suitability or determinations of the Department of State.
- **Coroners, Medical Examiners, and Funeral Directors**. I may release protected health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. I may also disclose protected health information to funeral directors consistent with applicable law to enable them to carry out their duties.
- **Correctional Institutions and Other Law Enforcement Custodial Situations**. If you are an inmate of a correctional institution or under the custody of a law enforcement official, I may release protected health information about you to the correctional institution or law enforcement official as necessary for your or another person's health and safety.
- **Worker's Compensation**. I may disclose information as necessary to comply with laws relating to worker's compensation or other similar programs established by law.
- **Food and Drug Administration**. I may disclose to the FDA, or persons under the jurisdiction of the FDA, protected health information relative to adverse events with respect to drugs, foods, supplements, products and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

YOU CAN OBJECT TO CERTAIN USES AND DISCLOSURES

Unless you object, or request that only a limited amount or type of information be shared, I may use or disclose protected health information about you in the following circumstances:

- I may share with a family member, relative, friend, or other person identified by you protected health information directly relevant to that person's involvement in your care or payment for your care. I may also share information to notify these individuals of your location, general condition, or death.
- I may share information with a public or private agency (such as the American Red Cross) for disaster relief purposes. Even if you object, I may still share this information if necessary for the emergency circumstances.

If you would like to object to use and disclosure of protected health information in these circumstances, please call or email me.

YOUR RIGHTS REGARDING PROTECTED HEALTH INFORMATION ABOUT YOU.
You have the following rights regarding protected health information I maintain about you:

- **Right to Inspect and Copy**. You have the right to inspect and copy protected health information that may be used to make decisions about your care. Usually, this includes medical and billing records. To inspect and copy protected health information that may be used to make decisions about you, you must submit your request in writing to me. If you request a copy of the information, I may charge a fee for the costs of copying, mailing, or other supplies associated with your request, and I will respond to your request no later than 30 days after receiving it. There are certain situations in which I am not required to comply with your request. In these circumstances, I will respond to you in writing, stating why I will not grant your request and describe any rights you may have to request a review of my denial.
- **Right to Amend**. If you feel that protected health information I have about you is incorrect or incomplete, you may ask me to amend or supplement the information. To request an amendment, your request must be made in writing and submitted to me. In addition, you must provide a reason that supports your request. I will act on your request for an amendment no later than 60 days after receiving the request. I may deny your request for an amendment if it is not in writing or does not include a reason to support the request, and I will provide a written denial to you. In addition, I may deny your request if you ask me to amend information that:
    - Was not created by me, unless the person or entity that created the information is no longer available to make the amendment;
    - Is not part of the protected health information kept by me;
    - Is not part of the information which you would be permitted to inspect and copy; or
    - I believe is accurate and complete.
- **Right to an Accounting of Disclosures**. You have the right to request an "accounting of disclosures." This is a list of the disclosures I made of protected health information about you. To request this list or “accounting of disclosures,” you must submit your request in writing to me. You may ask for disclosures made up to six years before your request (not including disclosures made before April 14, 2003). The first list you request within a 12-month period will be free. For additional lists, I may charge you for the costs of providing the list. <u>I am required to provide a listing of all disclosures except the following:</u>
    - For your treatment
    - For billing and collection of payment for your treatment
    - For health care operations
    - Made to or requested by you, or that you authorized
    - Occurring as a byproduct of permitted use and disclosures
    - For national security or intelligence purposes or to correctional institutions or law enforcement regarding inmates
    - As part of a limited data set of information that does not contain information identifying you
- **Right to Request Restrictions**. You have the right to request a restriction or limitation on the protected health information I use or disclose about you for treatment, payment, or health care operations or to persons involved in your care. <u>I am not required to agree to your request</u>. If I do agree, I will comply with your request unless the information is needed to provide you emergency treatment, the disclosure is to the Secretary of the Department of Health and Human Services, or the disclosure is for one of the purposes described on pages 2-3. To request restrictions, you must make your request in writing to me.
- **Right to Request Confidential Communications**. You have the right to request that I communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that I only contact you at work or by mail. To request confidential communications, you must make your request in writing to me. I will accommodate all reasonable requests.
- **Right to a Paper Copy of This Notice**. You have the right to a paper copy of this Notice at any time by contacting me.

OTHER USES AND DISCLOSURES

I will obtain your written authorization before using or disclosing your protected health information for purposes other than those provided for above (or as otherwise permitted or required by law). You may revoke this authorization in writing at any time. Upon receipt of the written revocation, I will stop using or disclosing your information, except to the extent that I have already acted in reliance on the authorization.

YOU MAY FILE A COMPLAINT ABOUT MY PRIVACY PRACTICES

If you believe your privacy rights have been violated, you may file a complaint with me or file a written complaint with the Secretary of the Department of Health and Human Services. A complaint to the Secretary should be filed within 180 days of the occurrence or action that is the subject of the complaint. If you file a complaint, I will not take any action against you or change my treatment of you in any way.

Please know that any information submitted via email or over the internet cannot be guaranteed as protected. You are sending this information at your own risk. If you are not comfortable with this policy, please communicate with me by phone, regular mail, or in person. Thank you for understanding.

Please sign/date, and return the Acknowledgement Confirming Receipt of Privacy Notice below.

We will keep this acknowledgment in your medical nutrition therapy record. Please retain a copy for yourself.

Acknowledgment Confirming Receipt of Privacy Notice

I acknowledge receiving a copy of Caroline L. Young, MS, RD, LD, RYT (LLC) HIPAA Notice of Privacy Practices.

Printed Name of Client: ____

Signature of Client: ____ Date: ____________________

Signature of Parent: ____ Date: ____________________

Or Guardian (if < 18 yrs. old)

Comments:

____
____
____
____

Payment & Cancellation Agreement

Please read each statement carefully and initial that you have read and agree to the terms.

_____All services may be paid with cash, check or credit card. **Please make all checks payable to Marietta Counseling for Children & Adults.**

______All appointment cancellations must be completed 24 hours in advance. Failure to cancel within 24 hours will require a charge (50% of session price).

_____Caroline L. Young, MS, RD, LD, RYT (LLC) does not currently accept insurance, however I am glad to provide you with a superbill to submit to your insurer for reimbursement, for our sessions. The superbill does not guarantee reimbursement.

_____Caroline L. Young, MS, RD, LD, RYT (LLC) does not provide any refunds.

I understand that by working with Caroline L. Young, MS, RD, LD, RYT (LLC), I must comply with the payment and cancellation policies listed above. This not only respects the time and expertise provided, but will also help me to make progress on the goals and plans that I have committed to. By signing this agreement, I am indicating that I understand these policies and agree to adhere to them.

I also understand that the recommendations and education provided should not be used in place of medical advice.

Signature: ____ Date: _______________

For questions or comments regarding these policies,
please contact Caroline at thewholeyogiRD@gmail.com.

New Client Registration Page

Name		DOB	
Address			
Relationship Status		SSN		Sex	M F Intersex Transgender

Name		DOB	
Address			

Relationship Status		SSN		Sex	M F Intersex Transgender

Contact Information

Phone	
Email Address	

Primary Care Physician

Name		Phone #	
Address			
Relationship with Physician (i.e. what do you seen him/her for, when was your last apt, etc.)			

Therapist/Counselor

Name		Phone #	
Address			
Relationship with Physician (i.e. what do you seen him/her for, when was your last apt, etc.)			

Additional Provider (i.e. psychiatrist)

Name		Phone #	
Address			
Relationship with Physician (i.e. what do you seen him/her for, when was your last apt, etc.)			

☐ **I give Caroline L. Young, MS, RD, LD, RYT permission to speak with and disclose my protected health information with the above-named treatment providers.**

Signature: ____ Date: _____________

Nourish Your Whole Self.

Nutrition Consultation Questionnaire

Date of Initial Assessment: _______________

Name: _______________________________________ Age: _________

Occupation (what are you doing in life and how do you feel about it?): ________________

____

____

Who do you live with? ____

Emergency Contact Name: ____

Phone: __________________________ Email: __________________________

- -

Purpose of our Consult

Tell me about why we are meeting. What do you feel is the primary purpose?

____

____

____

____

Relevant Family History- Share with me any family dynamics you feel are important for me to know/understand.

____

____

____

____

Does anyone in your family have a history of dieting, disordered eating, or eating disorders? Other chronic illnesses?

____

____

What was food like in your house growing up?

____

____

What is it like now?

____
____

What food beliefs, rituals and patterns did you inherit from your family, or learn from friends or the media that still have influence in your life?

____
____
____
____

Which food/body beliefs and behaviors do you continue to accept that you know are not true, and/or would like to change?

____
____
____
____

Describe food/body beliefs and behaviors you have that you'd like to strengthen and/or develop, and would like to pass on to others.

____
____
____
____

Weight

You can leave blank, if you prefer, and we can discuss it in session together.

Height: ____________ Current weight: ________________

Average weight for the past 2 to 3 years? ______________

Weight you feel most comfortable ________ When were you last at that weight? ______

Highest adult weight? __________________ Age: _____________

Lowest adult weight? ____________ Age: _____________

Pre-pregnancy weight? ___________ How much weight did you gain with pregnancy? __

Have you lost or gained weight recently? _______________

How much? ______________Time frame? _____________

Do you weigh yourself currently? If yes, how frequently ___________________________

Nourish Your Whole Self.

Please circle how you currently feel about your body.

strongly dislike dislike slightly satisfied satisfied very satisfied

Food & Nutrition

Do you *(circle or bold Y or N):*

- Count calories? Y N
- Restrict your food? Y N
- Avoid certain food groups? Y N
- Binge eat? Y N
- Use laxatives, diet pills or diuretics? Y N
- Self harm in response to eating? Y N
- Induce vomiting an/oror purging via exercise? Y N
- Eat “normally”? Y N
- Eat foods that are different from your family and friend’s foods? Y N
- Weigh/measure your food? Y N
- Count fat and/ or carb grams? Y N
- Scared to try new foods? Y N
- Eat the same foods everyday? Y N
- Uncomfortable eating in front of others? Y N
- Compare what you eat to what others eat? Y N
- Hide food? Y N
- Feel guilty and/or ashamed after eating? Y N
- Feel like food and/or exercise controls your life? Y N
- Believe there are good foods and bad foods? Y N
- Refuse to eat after a certain hour? Y N
- Avoid eating a food if you don’t know its nutritional content and/or how it was prepared? Y N
- Become upset if you eat foods other than what was planned? Y N
- Turn to or away from food to numb painful emotions? Y N

Have you ever been diagnosed with an eating disorder? If so, please explain.

____

____

How many times have you tried to control your weight? ___

Age at first attempt ___ years Your height at that time? ___ Weight? ___

What did you do? Please explain your reasons to control your weight.

____

____

Have you ever heard of intuitive eating? If so, have you tried it?

____

____

Eating Patterns

How many meals a day do you eat? ______________

Do you skip meals? _______________

If yes, which ones do you skip and why? ____

What are your snacking habits (i.e. frequency, time of day, foods you choose)? ________

____

____

How many meals per week do you eat at a restaurant? __________

How does your meal and snack pattern vary on the weekend vs. during the week? _____

____

____

When you feel overwhelmed or life gets busy, do you neglect your eating habits? □ yes □ no

If yes, please describe. ____

____

Do you feel that your life/schedule conflicts with nourishing your body in the way you'd like to?

□ yes □ no If yes, please describe. ____

____

Do you eat and multi-task (i.e. read, watch TV, drive) □ yes □ no If yes, please describe:

____

____

Where do you eat your meals? ____

Do you feel you eat particularly fast or slow? □ yes □ no If yes, please describe: ______

____

Do you cook? □ yes □ no Do you know how to cook? □ yes □ no

Do you like to cook? □ yes □ no

Nourish Your Whole Self.

Who does the grocery shopping? _________Who prepares the food at home? __

Do you read food/nutrition labels? □ yes □ no

What do you look for on labels? ____

____

Please list the usual time and **typical** daily intake for each meal.

Breakfast: ____

Lunch: ____

Dinner: ____

Snacks: ____

Beverages: ____

What foods do you love? ____

What foods do you dislike? ____

Are there any foods that feel like “fear” foods for you? __________________________

Are there any foods that feel “safe” to you? ________________________________

Digestive Health

Have you ever received a gastrointestinal (GI) diagnoses? □ yes □ no

If yes, please describe. ____

____

Did you have any GI issues as child or adolescent? □ yes □ no

If yes, please describe. ____

Are there significant GI issues in your family? □ yes □ no

If yes, please describe. ____

Do you have any food allergies?___________
Have you been tested for food allergies? ________________________________
If yes, please list: ____
Do you have any food intolerances?________
Have you been tested for food intolerances? ______________________________

If yes, please list: ____________________

GI symptoms:

On a scale of 1-10 (10 = terrible, 0=non-existent) please state a number that identifies the level intensity of the following symptoms:

Gas 1 2 3 4 5 6 7 8 9 10

Bloating 1 2 3 4 5 6 7 8 9 10

Nausea 1 2 3 4 5 6 7 8 9 10

Diarrhea 1 2 3 4 5 6 7 8 9 10

Constipation 1 2 3 4 5 6 7 8 9 10

Abdominal Pain 1 2 3 4 5 6 7 8 9 10

Reflux/ (GERD) 1 2 3 4 5 6 7 8 9 10

Dysphagia 1 2 3 4 5 6 7 8 9 10

Incomplete emptying 1 2 3 4 5 6 7 8 9 10

Fecal Incontinence 1 2 3 4 5 6 7 8 9 10

Based on the above symptoms, how frequently during the week or month do your symptoms impact your quality of life? ____________________

Exercise and Activity

Have you ever had a consistent exercise/movement routine? □ yes □ no

If yes, tell me about your past exercise habits/relationship to exercise/movement. ______

____

Are you following one currently? □ yes □ no

If yes, please describe: ____________________

____

Tell me how you feel about exercise/movement. ____________________

____

Medical History & Personal Health

Please list/describe any medical diagnoses or procedures I should be aware of.

____

____

If applicable, are you currently getting your period? □ yes □ no

If applicable, have there been any inconsistencies with your menstrual cycle? □ yes □ no

If yes, please describe. ____________________

____

Please list your current medications & supplement dosages: ______________________

____

____

Please list/describe any mental health concerns should I be aware of (i.e. depression, anxiety, OCD, PTSD)? ____

____

Please share any illicit drug, alcohol, cigarette use. ____________________________

____

____

Rate your health: □ excellent □ good □ fair □ poor

Rate your current perceived level of stress on a scale of 1-10: _________
How much sleep do you get a night? How's the quality? _________________________

____

On a scale of 1-10, 10 being the highest, how much support do you need when making lifestyle changes? _________
Do you have a strong support system? Please describe. _________________________

____

Have you ever worked with a dietitian/nutritionist? □ yes □ no

If yes, tell me about your experience. ______________________________________

____

____

Do you have any self-care practices in place right now? If yes, please describe. ________

____

____

Which types of self-care practices appeal to you? _____________________________

____

What does self-compassion mean to you?

____

____

What are your life's deepest passions?

____

____

What do you value most and what are you most grateful for in your life?

____

____

Do you have any spirituality practices in place? If so, please briefly describe. If not, do you feel a need to find one?

____

____

To accompany our work together, are you open to *(bold or circle Y or N):*

- Yoga and/or guided meditation? Y N
- Breathing exercises? Y N
- Body scans? Y N
- Journaling? Y N

What types of social media do you use? ___________________________________

How do you feel social media affects you? ______________________________________

____

Today's Session

What do you hope to accomplish through our visit today?

What are your short-term intentions?

What are your long-term intentions?

Please feel free to share any additional information or concerns here.

This concludes the Foundation Packet. Please remember, this is a process. It's a journey that I am honored to be taking with you. I am looking forward to our first session. See you then!