Patty Murphy, MS, CNS
Nutritionist
Plate Journey Nutrition

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WELCOME

Welcome to Plate Journey Nutrition. It is my goal to offer you guidance in your nutritional needs that can assist you in attaining and maintaining wellness through a healthful diet and nutritional therapeutics to reduce the risk of chronic disease and to aid in the treatment of existing conditions and weight loss or maintenance.

For your comprehensive initial consultation the following forms are to be completed and emailed back to me or brought with you to our session.

- Dietary Intake Form
- Health History Form with Physical Activity Information

The fee for the 60-minute initial consultation includes discussion and development of a program to achieve our goals. Your initial consultation will include, where indicated:

- Complete, individualized dietary and lifestyle recommendations.
- Natural complimentary programs for treating existing conditions such as high blood pressure, high cholesterol, food allergies and sensitivities, PMS/PCOS/endometriosis, insulin resistance/ diabetes, cancer, autoimmune disease, irritable bowel syndrome and other digestive disorders, allergies, asthma, fibromyalgia, peri-menopause and menopause, arthritis, and heart disease.
- Individualized programs for weight loss and management and improved body composition.
- Rebuilding and strengthening of the immune system
- Individualized vitamin & supplement profiles to match your specific lifestyle demands, genetic predisposition or current medical condition – Please bring the supplements you are currently taking to your consultation.

Nutritional Consultation Fees

Initial Assessment and Consultation	$95.00
Follow-up Consultations	$55.00
3 visit program – Initial individual consultation plus 3 follow-up consultations	$250.00
Couples initial consultation	$150.00
Couples Follow-up Consultations	$75.00
Each Referral to friend or family	50% off a follow-up visit
1 Week Menu Plan with recipes – standard	$65
1 Week Menu Plan with recipes – complex	$80
Hours for Consultations: (by appointment)	

Payment is expected at the time of service in the form of cash or personal check. Credit card payments are also accepted through PayPal. A 24-hour notification is requested in the event you need to cancel an appointment.

These services are at all times restricted to the consultation of the subject of nutritional and wellness matters intended for the maintenance of a state of nutritional health and do not involve the diagnosis of disease. It is my goal to be part of your health care team and work with you and your doctors to assist you in your personal health goals.

Consultations are available at 2 office locations – at Elevate Albany Wellness, Suite 200, 407 Albany Shaker Road, Loudonville, NY 12211 or 11725 Duanesburg Road, Delanson, NY 12053. I am also available for online video consultations through HIPAA-compliant Doxy.me. This simple platform allows for secure consultations from the privacy of your home. No need to download anything, just follow the provided link to my Doxy.me URL, check-in and we're ready to go. Please fill out all forms as completely as possible, scan and email them back to me prior to your appointment. If you have any questions, please feel free to contact me at 518-368-4379 or patty@platejourney.com. I welcome the opportunity to work with you as you begin your journey towards improving your diet and health.

Be well,

Patty Murphy, MS,CNS

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Dietary Intake Form

Please fill out the Dietary Intake Form below as accurately as possible. Include what represents a typical meal for breakfast, lunch, and dinner, and any snacks. Include approximate serving sizes for each food and beverages as well. Two areas are provided for each meal or snack where you can provide alternate meals.

Meal or Snack	**Typical Meal** **Variation 1**	**Typical Meal** **Variation 2**
Breakfast		
Morning Snack		
Lunch		
Afternoon Snack		
Dinner		
Evening Snack		

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HEALTH HISTORY FORM

Name: _____Date: _____

Address:_____

City: _____ State: _____Zip:_____

Home Phone: _____ Work Phone:_____

Cell Phone: _____ E-Mail_____

Date of Birth: _____ Age: _____ Marital Status:_____

Referred by: _____ Occupation: _____

Physician: _____ Phone: _____

Main Complaint **(symptoms, diagnosis, duration, etc.)**

☐Female ☐Male

Height_____ **Weight**_____

Significant Trauma (physical or emotional)

Birth History (number, complications, etc.)

Surgeries (please include date of procedure)

Allergies/Sensitivities (food, chemical, environmental, drugs, etc.)

Medications (names & dosages) Please attach an additional page if necessary.

Vitamins/Supplements/Herbs Please bring supplement containers to your initial consultation.

What makes your condition better? (Rest, movement, heat, cold, fresh air, eating, crying, etc.)

What makes your condition worse? (stress, fatigue, hunger, heat, certain foods, damp days, etc.)

Health History

Personal History

Please check any conditions or symptoms you have now.

- ☐ Arthritis
- ☐ Kidney Disease
- ☐ Food Allergies, _____
- ☐ Anemia
- ☐ Asthma
- ☐ Liver/Gall Bladder Disease
- ☐ High Cholesterol
- ☐ Hypothyroid
- ☐ Chronic Pain Condition
- ☐ Heart Disease
- ☐ Cancer
- ☐ Diverticulitis
- ☐ Respiratory Allergies
- ☐ PMS/Menopause
- ☐ High Blood Pressure
- ☐ Diabetes
- ☐ Chronic Fatigue
- ☐ IBS
- ☐ Other_____

Testing History

Please give all test results ordered by your physician, where applicable, or bring a copy of your results with you to your appointment If you do not have these, please please obtain these from your physician.

Blood Pressure_____/_____	Triglycerides_____	A1C_____	_____
Total Cholesterol_____	Homocysteine_____	Thyroid – TSH_____	_____
HDL Cholesterol_____	C-Reactive Protein_____	Other: Please list test and result	_____
LDL Cholesterol_____	Blood Glucose_____	_____	_____

Family Medical History

Please check any condition that applies to your immediate family. Put an F (father), M (mother), S (sister), B (brother), GM (grandmother), GF (grandfather) next to choice.

- ☐ Diabetes ___
- ☐ Allergies ___
- ☐ Other_____
- ☐ Heart Disease ___
- ☐ Cancer ___
- ☐ Stroke ___
- ☐ Asthma ___
- ☐ High Blood Pressure ___

Please **check** if you have had any of these items listed below in the last **year**
Put a **star** on the box if you had this in the past but do not any longer.

General

- ☐ Poor Appetite
- ☐ Cravings
- ☐ Poor Sleeping
- ☐ Poor Balance
- ☐ Fatigue
- ☐ Weight loss/gain
- ☐ Night Sweats
- ☐ Fatigue

Skin and Hair

- ☐ Rashes/Dermatitis
- ☐ Eczema/Psoriasis
- ☐ Loss of hair
- ☐ Weak or ridged nails

Head, Eyes, Ears, Nose and Throat

- ☐ Dizziness
- ☐ Ringing in ears
- ☐ Post nasal drip
- ☐ Difficulty swallowing
- ☐ Poor hearing
- ☐ Headaches
- ☐ Migraines
- ☐ Spots in front of eyes
- ☐ Earaches
- ☐ Sinus problems

Cardiovascular

- ☐ Chest pain or pressure
- ☐ Low blood pressure
- ☐ Irregular heart beat
- ☐ Dizziness
- ☐ Shortness of breath
- ☐ High blood pressure

Respiratory

- ☐ Cough/Wheezing
- ☐ Frequent Colds
- ☐ Hay Fever / Rhinitis
- ☐ Smoking – current smoker ☐; past smoker☐
- ☐ Asthma
- ☐ Bronchitis

Gastrointestinal

- ☐ Nausea
- ☐ Gas
- ☐ Abdominal pain
- ☐ Vomiting
- ☐ Indigestion
- ☐ Acid reflux/GERD
- ☐ Diarrhea
- ☐ Hemorrhoids
- ☐ IBS/Crohn's Disease
- ☐ Constipation
- ☐ Bloating

List any other conditions/symptoms that apply in the following areas:

Urinary_____

Gynecological/Reproductive_____

Musculoskeletal_____

Neuropsychological_____

Comments Please inform me of any other topics or problems you would like to discuss.

_____

_____

_____

Physical Activity Please list your typical physical activity done in an average week.

Aerobic /Cardio	**Duration**	**Frequency**
Strength	**Duration**	**Frequency**
Stretching	**Duration**	**Frequency**