



Nutrition  
HEALING

Morgan Mellas Telor, CNC

Phone: 323-549-0070

Fax: 323-549-0440

Thank you for your interest in an appointment with Morgan Mellas Telor, CNC. Please take a moment to read through this information as it will help you understand who Morgan is, what she does, what to expect at your first appointment and future communication.

Morgan Mellas Telor is a Nutrition Therapist. Her focus is on long-term, client-centered counseling to assess, educate, and manage a client's nutrition and the influencing factors, so as to meet their therapeutic and wellness goals. Her practice is governed by the *Code of Ethics for the Profession of Dietetics (1987)*.

Enclosed is your New Patient Packet. It will take you approximately 30-45 minutes to complete the paperwork. Please fill out these forms completely and return them to our office via mail or fax. Note that in the packet you will find two papers for your health care provider. One is the Diet Prescription and we would like you to have your primary care physician sign in, however it is not mandatory. We prefer to have your primary care physician sign it so that they are well informed that you are seeing a nutritionist. The other is a list of Recommended Nutritional Labs that we request you complete through your doctor's office. If you already have current blood tests (within **6 months**) you may use those instead. If you do not have or do not wish to get blood work, a nutritional assessment can be done, however, it will not be as thorough as it could be, and many supplement recommendations cannot be made.

At your first appointment Morgan will review the questionnaires in your New Patient Packet as well your blood tests. Other in-office tests may be recommended for an additional fee. Once all the questionnaires and test results have been discussed, Morgan will create a Nutrition Action Plan with you that may include all or some of the following: **recommended lifestyle changes, recommended blood tests, tests kits, referrals to other practitioners, and a supplement regimen** to help you reach your goals as quickly and healthily as possible.

Payment for the appointment is due in full the day of service. We do not accept any insurance. At the time of check-out, an appointment will be set for a follow-up email or phone call with Morgan for the following week. This call is designed to be a quick follow-up (less than 15 minutes) just to take down any questions you may have once you have had a few days to review your paperwork and start your plan. You will then receive another call to provide you with any answers you need and also to set-up your follow-up appointment with Morgan. For any urgent questions or if you have any negative reactions to your plan, please call as soon as possible.

Now that you have read through Morgan's information please complete the New Patient Packet. We have provided a checklist to help ensure all forms are provided and complete. Once complete, please fax, email or mail it to our office at:

Morgan Mellas Telor, Nutrition Therapist

Berlin Wellness Group

6221 Wilshire Boulevard, suite 518

Los Angeles, CA 90048

Phone: 323.549.0070, Fax: 323.549.0440

Again, thank you for your interest and we look forward to working with you!



*Nutrition*  
*HEALING*

Phone: 323-549-0070

Fax: 323-549-0440

Welcome to Nutrition Healing with Morgan Mellas Telor, Nutrition Therapist.

Your ***New Patient Packet*** contains all the information you will need for your Initial Assessment. Please follow the directions in this packet.

**IMPORTANT FOR YOUR APPOINTMENT:**

- **SUPPLEMENTS:** Please **bring the bottles** for any supplements or medications you are taking.
- **CLINICAL TESTS:** At your appointment we may perform clinical tests that may include the following: oral zinc test, an oral pH test, and a Bioelectrical Impedance test (BIA). For a proper BIA reading please:

- |  |  |
|--|--|
| <ul style="list-style-type: none"><li>○ <b>Do not</b> eat 1 hour prior</li><li>○ <b>Do not</b> exercise 4 hours prior</li><li>○ <b>Do not</b> consume alcohol 24 hours prior</li></ul> | <ul style="list-style-type: none"><li>○ <b>Do not</b> have caffeine the day of test</li><li>○ <b>Drink</b> 16 ounces of water upon arising</li></ul> |
|--|--|



Our office is an “allergy-free” zone. Please be considerate of your fellow patients and avoid wearing perfume/strong lotions or bringing any pets.

**Driving Directions to:**

**BERLIN WELLNESS GROUP**

Phone: (323) 549-0070

6221 Wilshire Blvd. Suite 518

Los Angeles, CA 90048

Located on Wilshire Boulevard, one block west of Fairfax Avenue.

**ALL PATIENT INFORMATION IS HANDLED UNDER THE HIPPA PRIVACY ACT**

**CONFIDENTIAL**

## Fee Schedule

All **follow-up** assessments are billed at the rate of \$99.00 per hour. For you convenience there is breakdown below of our most common types of assessments plus the rates for our clinical testing.

<b>Service</b>	<b>Price</b>
Initial Consultation with Clinical Tests: Office Visit or Phone Consult (up to 90 minutes)	\$149.00
Follow-up Consultation: Office Visit or Phone Consult (1 hour)	\$99.00
Initial Consultation <b>AND</b> Two Follow-up Consultations: Office Visit or Phone Consult (10% off when prepaid. Regular pricing \$347.00)	\$309.00
Unlimited email Follow-up One Month (questions, concerns, updates, new ailments and all other inquiries via email)	\$79.00
Unlimited email Follow-up Three Months (questions, concerns, updates, new ailments and all other inquiries via email)	\$199.00

**NOTE:** All fees will be disclosed to the patient prior to the appointment. All phone consultations need to have payment arrangements made prior to the consultation.

Please use the following checklist to make sure that all the necessary pages have been included in your packet and to mark them off as you complete them. Please understand that all of this information is necessary for Morgan to be able to do an assessment and must be completed returned to our office before you can book an appointment.

Diet Prescription has been **SIGNED by my health care provider.**

(An assessment cannot be done without one!)

Patient Registration Form completed

Notice/Consent Form signed in all three places

Nutrition/Health Questionnaire completed

Medical Conditions completed

Current Eating Habits completed

Fat/Oils Worksheet completed

List of Medications and Supplements completed

Diet Diary/Exercise Log completed

Authorization for Release of Records filled out, **INITIALED**, and signed

Copy of recent blood tests



Nutrition  
HEALING

Phone: 323-549-0070  
Fax: 323-549-0440

DATE \_\_\_\_\_

RE: \_\_\_\_\_  
PATIENT NAME

SSN: \_\_\_\_\_  
PATIENT SOCIAL SECURITY NUMBER

Dear Doctor \_\_\_\_\_:

Your patient has requested an appointment with me for a nutritional assessment and dietary counseling. I have informed him/her of the need for a Dietary Prescription (Referral) from a physician to proceed.

**Under CA Business & Professions Code Section 2586 (a) a Nutritionist must have a written and signed referral from a health care provider in order to provide medical nutrition therapy.**

Please complete the following Diet Prescription Form and return to my office with your Diagnosis and Diet Prescription so I can work within your direction for their nutritional care:

## DIET PRESCRIPTION

Diagnosis: \_\_\_\_\_

### Diet Rx (check/complete)

- Wellness / Regular Diet
- Diabetic: \_\_\_\_\_
- Heart Healthy Diet: \_\_\_\_\_
- Hypertensive Diet: \_\_\_\_\_
- Other Therapeutic: \_\_\_\_\_

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Physician Name: \_\_\_\_\_

Thank you for allowing me to participate in your medical management of you patient. Please let me know if you have any questions. You may call my office at 323-549-0070.

Sincerely,  
Morgan Mellas Telor  
Nutrition Healing

## NOTICE OF PRIVACY PRACTICES

The privacy of your medical information, as described in the HIPAA Privacy Act, is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our organization. We need this record to provide you with quality care and to comply with certain legal requirements.

We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us at the address provided at the end of this notice.

We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students or other health care providers to assist them in treating you. We may use and disclose your medical information for payment purposes. A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include your medical information.

Morgan Mellas Telor, Nutrition Healing  
Berlin Wellness Group  
6221 Wilshire Boulevard, suite 518  
Los Angeles, CA 90048  
14011 Hartsook Street  
Sherman Oaks, California 91423  
Ph: 818-742-1496 Fax: 323-549-0440

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Signed \_\_\_\_\_ Date \_\_\_\_\_

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## NOTICE

State law allows any person to provide nutritional advice or give advice concerning proper nutrition – which is the giving of advice as to the role of food and food ingredient, including dietary supplements. This state law does NOT confer authority to practice medicine or to undertake the diagnosis, prevention, treatment, or cure of any disease, pain, deformity, injury, or physical or mental condition and specifically does not authorize any person other than one who is a licensed health practitioner to state that any product might cure any disease, disorder, or condition.

Signed \_\_\_\_\_ Date \_\_\_\_\_

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## INFORMED CONSENT

I am solely responsible for the decision to see Morgan Mellas Telor. I recognize that Morgan Mellas Telor is not a licensed physician or a registered dietician. I recognize that Morgan Mellas Telor is a nutritional advisor without any formal license. I recognize that some recommendations may not prove to be successful. I understand some recommendations may be novel. I agree to participate in an active manner, monitor my progress, and report any concerns to Morgan Mellas Telor or her staff. I also understand that any significant symptoms should be reported to my doctor. It is also recommended that I discuss the use of any nutritional supplements with my doctor before implementing.

Signed \_\_\_\_\_ Date \_\_\_\_\_

**CONFIDENTIAL**

Name: \_\_\_\_\_

Date: \_\_\_\_\_

## **Nutrition/Health Questionnaire**

### **GENERAL QUESTIONS:**

- Please list below the 4 main complaints you have, in order of importance.

1. \_\_\_\_\_ 3. \_\_\_\_\_  
 2. \_\_\_\_\_ 4. \_\_\_\_\_

- Please fill in your approximate: Height \_\_\_\_\_ Weight \_\_\_\_\_ Healthy Body Weight \_\_\_\_\_  
 Do you consider yourself (circle one)? Correct weight Overweight Underweight

- Do you follow a medically prescribed diet? Y N If so, what is it?

\_\_\_\_\_  
 Doctor's Name (who prescribed diet): \_\_\_\_\_ Phone: \_\_\_\_\_

Please list any FOOD ALLERGIES:

\_\_\_\_\_  
 Please list any non-food allergies:

\_\_\_\_\_  
 What allergic symptoms do you experience (both food and non-food)? \_\_\_\_\_

How often do you have BOWEL MOVEMENTS? >3/day 1-3/day 1/week

Describe Consistency \_\_\_\_\_

- How often do you exercise? \_\_\_\_\_ What type of exercise? \_\_\_\_\_  
 How many hours do you sleep each night? \_\_\_\_\_ Why? \_\_\_\_\_  
 How many times do you wake-up in the night? \_\_\_\_\_

### **HOSPITALIZATIONS:**

Please list all inpatient hospitalizations: (medical, surgical, biopsies, fractures, obstetric/gynecologic and psychiatric).

Start with the most recent admission.

Nature of Medical Conditions	Date	
Nature of Hospitalizations		Hospital

Other Significant Health Conditions:

\_\_\_\_\_

Other Mental Health Conditions:

\_\_\_\_\_

Name: \_\_\_\_\_

Date: \_\_\_\_\_

**FAMILY HISTORY:**

Indicate if family members have had the following diseases in the table below.

*Heart Disease    High Blood Pressure    Stroke    Mental Illness    Alzheimer's/MS    Bleeding Tendency*  
*Overweight    Lung Disease    Kidney Disease    Birth Defects    Diabetes    Addiction*  
*Other: \_\_\_\_\_    Cancer (What type?)*

Family Member	Disease

Name: \_\_\_\_\_

Date: \_\_\_\_\_

**MEDICAL CONDITIONS:**

Please check "Y" if you have the listed condition. Check "N" if you do not have the listed condition.

	Y	N
<b>Nutrition &amp; Digestion</b>		
Are you on a vegan diet (vegetarian, no eggs, dairy, fish)?		
Do you feel like belching, or are bloated after eating?		
Do you see undigested food or a greasy film in the toilet?		
Do you lose weight easily or is it hard to gain weight?		
Do you get heartburn/acid reflux? _____ times/week		
Are your fingernails soft, brittle or have white spots?		
Are you prone to muscle cramps? Which muscles? _____		
Do you have poor night vision?		
Do you have or have you had an Ulcer?		
Do you have or have you had gall bladder disease?		
Do you have thyroid problems?		

	Y	N
<b>Endocrine Balance</b>		
Are you under excessive stress?		
Do you feel worse if you skip a meal and/or eat sweets?		
Do you suddenly feel dizzy upon standing?		
Do you have difficulty falling asleep, staying asleep, or wake unrefreshed?		
Are you more tired or depressed during the winter?		
Are you fatigued, constipated, gaining weight, dry skin or cold? (circle any that apply)		
Do you have excess stomach weight? Starting Age _____		
Has your sex drive declined?		
<b>Women Only:</b>		
Do you feel worse pre-menstrually?		
Has your menstrual cycle recently changed?		
Have you felt worse since menopause?		
Have you used oral contraceptives/birth control pills?		
Have you ever been pregnant? How many times?		
<b>Men Only:</b>		

	Y	N
<b>Immune Balance</b>		
Do you have more than 2 colds or flu's per year?		
Are you slow to recover from infections?		
Do you frequently have swollen lymph nodes in the neck, armpit or groin?		
Do you have seasonal allergies?		
Do you have itchy eyes, nose, palate, throat or skin?		
Are you sensitive to molds, dust, pets or other parts of the environment?		
Do you experience chronic sinus congestion, "post-nasal drip"/excess mucus?		
Do you feel worse after eating certain foods?		
Do you have dark circles under the eyes?		
Do you have asthma?		
Have you ever had an autoimmune disease?		
Do you have joint pain? Which joints? _____		
Have you ever smoked or chewed tobacco?		
No. of years _____ If you have quit, when? _____		
Cigarettes: packs per day _____		
Cigars: no. per day _____		
Chewing tobacco _____ Pipe _____		
Do you or have you had cancer? If so, which type _____		
Have you ever had or do you have lung problems?		
Have you had an abnormal chest x-ray?		

	Y	N
<b>Detoxification</b>		
Are there toxic chemicals or metals at work or home?		
Do you have or had amalgam (silver) fillings? Amt. __		
Are you prone to side effects from medications?		
Have you become more sensitive to alcohol?		
Are you forgetful or have problems thinking		

Do you have problems achieving or maintaining an erection?		
Have you recently felt tired or less motivated?		

<b>Elimination</b>		
Do you suffer from constipation and/or diarrhea?		
Do you have dry, hard or small stool?		
Do you ever see mucus or blood in your stool?		
Do you experience frequent gas or bloating?		
Do you suffer from abdominal discomfort or cramping?		
Have you had 2 or more antibiotics in your lifetime?		
Do you sweat profusely, or is it particularly odorous?		
Do you have kidney or bladder problems?		
Have you had a bowel polyp?		
Do you have Colitis (Ulcerative Colitis, Crohns)?		
Do you have irritable bowel syndrome (Spastic Colitis)		
Do you have or have you had Diverticulitis?		

clearly?		
Are you sensitive to smells i.e. car exhaust, perfumes, household cleaners or cigarette smoke?		
Have you had liver disease, hepatitis, mononucleosis or elevated liver enzymes?		
Are your muscles stiff/sore/fatigued with exercise?		
Are you worn out or “spacey” using a sauna/Jacuzzi?		
Do you experience a metallic taste in your mouth?		
Do you have or had problems with alcoholism?		
Have you had or do you have Epilepsy or seizures?		
<b>Have you had the following conditions?</b>		
Glaucoma		
High blood pressure		
Stroke		
Arthritis		
Gout		
Bleeding tendency		

Name: \_\_\_\_\_

Date: \_\_\_\_\_

## Current Eating Habits

Mark which meals you eat regularly:      Breakfast      Lunch      Dinner      Snacks      (circle all applicable)

Mark how many times you eat or drink the following items **per week**.

<input type="checkbox"/> Soda – reg.	<input type="checkbox"/> Rice Milk	<input type="checkbox"/> Dried Fruit	<input type="checkbox"/> Cereals
<input type="checkbox"/> Soda – diet	<input type="checkbox"/> Almond Milk	<input type="checkbox"/> Canned Fruit	<input type="checkbox"/> <b>Crackers</b>
<input type="checkbox"/> Alcohol	<input type="checkbox"/> Goat Milk	<input type="checkbox"/> Fresh fruit	(What Type)
<input type="checkbox"/> Hot tea	<input type="checkbox"/> Jello	<input type="checkbox"/> Jelly/Jam/Fruit Spread	_____
<input type="checkbox"/> Cold tea	<input type="checkbox"/> Fast food	<input type="checkbox"/> Frozen Fruit	_____
<input type="checkbox"/> Coffee – reg.	<input type="checkbox"/> Restaurants	<input type="checkbox"/> Salads	<input type="checkbox"/> Bagels/pretzels
<input type="checkbox"/> Coffee – decaf	<input type="checkbox"/> Candy		<input type="checkbox"/> Whole wheat bread
<input type="checkbox"/> Cream in coffee	<input type="checkbox"/> Ice cream	<b>Raw Veggies</b>	
<input type="checkbox"/> Sugar in coffee	<input type="checkbox"/> Pudding	What kind?	<input type="checkbox"/> White bread
<input type="checkbox"/> Sweetened	<input type="checkbox"/> Refined sugars	_____	<input type="checkbox"/> Sprouted bread
<input type="checkbox"/> Coffee drinks		_____	<input type="checkbox"/> Pasta
<input type="checkbox"/> Non-carbonated sweetened drinks	<b>Artificial Sweeteners</b>	<b>Cooked Veggies</b>	<input type="checkbox"/> Brown rice
	Equal/Nutrasweet	What kind?	<input type="checkbox"/> White rice
	Splenda/Sucralose	_____	<input type="checkbox"/> Corn tortillas
<input type="checkbox"/> Sparkling water	Saccharine/Sweet-n-Low	_____	<input type="checkbox"/> Flour tortillas
<input type="checkbox"/> Purified water	Stevia	<input type="checkbox"/> Yams	<input type="checkbox"/> Sprouted Tortillas
<input type="checkbox"/> Tap water	Lg. Fish (tuna, swordfish, halibut)	<input type="checkbox"/> Corn	<input type="checkbox"/> Chips
<input type="checkbox"/> Distilled water	Luncheon meats	<input type="checkbox"/> Russet Potatoes	(potato/tortilla)
<input type="checkbox"/> Fruit juice	Legumes (beans)	<input type="checkbox"/> Other Potatoes	<input type="checkbox"/> Pizza
<input type="checkbox"/> Lemonade	Egg whites	<input type="checkbox"/> Mashed potatoes	<b>Yogurt</b>
<input type="checkbox"/> Milk (Cow)	Whole Eggs	<input type="checkbox"/> Baked Potatoes	<input type="checkbox"/> Sweetened
<input type="checkbox"/> Soy Milk		<input type="checkbox"/> Popcorn	<input type="checkbox"/> Plain

Name: \_\_\_\_\_

Date: \_\_\_\_\_

## Fats/Oils Worksheet

**DIRECTIONS:** Indicate how many times per week you eat the following foods in the space provided.

### RATIOS

<u>Omega 9</u> Stabilizer	<input type="checkbox"/> Almond Oil <input type="checkbox"/> Avocado Oil <input type="checkbox"/> Tahini <input type="checkbox"/> Sesame Seeds <input type="checkbox"/> Almonds <input type="checkbox"/> Avocados <input type="checkbox"/> Hummus <input type="checkbox"/> Peanuts <input type="checkbox"/> Almond Butter <input type="checkbox"/> Olive Oil or Olives <input type="checkbox"/> Sesame Oil <input type="checkbox"/> Natural Peanut Butter	10
<u>Omega 6 EFA</u> Contollers	<input type="checkbox"/> Eggs (whole) <input type="checkbox"/> Filberts/Hazelnuts, raw <input type="checkbox"/> Grapeseed Oil Mayonnaise <input type="checkbox"/> Meats <input type="checkbox"/> Pistachios, raw <input type="checkbox"/> Evening Primrose Oil <input type="checkbox"/> Pumpkin Seeds, raw <input type="checkbox"/> Pine Nuts, raw <input type="checkbox"/> Black Current Oil <input type="checkbox"/> Brazil Nuts, raw <input type="checkbox"/> Walnuts, raw <input type="checkbox"/> Body Bio Oil <input type="checkbox"/> Pecans, raw <input type="checkbox"/> Hemp Oil <input type="checkbox"/> Flax Combo Refrig Oils	8
<u>Omega 3 EFA</u> Fluidity and Communicators	<input type="checkbox"/> Algae <input type="checkbox"/> Flax Oil <input type="checkbox"/> Fish, fresh or frozen <input type="checkbox"/> Super-food/Pure Nutrition <input type="checkbox"/> Body Bio Oil <input type="checkbox"/> Fish Oil <input type="checkbox"/> Flax Seeds, ground <input type="checkbox"/> Optiomega Oil <input type="checkbox"/> UDO's Oil	2
<u>Beneficial Saturated</u> Structure	<input type="checkbox"/> Coconut Oil <input type="checkbox"/> Sour Cream <input type="checkbox"/> Chicken <input type="checkbox"/> Cream <input type="checkbox"/> Ghee (clarified butter) <input type="checkbox"/> Turkey <input type="checkbox"/> Cream Cheese <input type="checkbox"/> Butter, real <input type="checkbox"/> Wild Game <input type="checkbox"/> Cheese (cow, goat, sheep) <input type="checkbox"/> Eggs (whole) <input type="checkbox"/> Meats	1

### **DAMAGED FATS/OILS – Should be < 5% of diet**

<input type="checkbox"/> Margarine <input type="checkbox"/> Food cooked w/ margarine <input type="checkbox"/> Regular Cooking Oil <input type="checkbox"/> Sunflower Oil <input type="checkbox"/> Corn Oil <input type="checkbox"/> Soybean Oil <input type="checkbox"/> Canola Oil <input type="checkbox"/> Commercial Mayonnaise <input type="checkbox"/> "Imitation" Cheeses	<input type="checkbox"/> Processed Velveeta Cheese <input type="checkbox"/> Non-Dairy Topping (Cool-Whip) <input type="checkbox"/> Roasted Non-Almond Nuts <input type="checkbox"/> Roasted Seeds <input type="checkbox"/> Vegetable Oils in food & clear bottles <input type="checkbox"/> Processed Foods (pastries, cookies, bakery products, muffins, crackers)	<input type="checkbox"/> Tempura <input type="checkbox"/> Doughnuts (fried) <input type="checkbox"/> Deep-Fried Foods <input type="checkbox"/> French Fries <input type="checkbox"/> Onion rings <input type="checkbox"/> Fried Zucchini <input type="checkbox"/> Chips fried in Oil (potato, corn) <input type="checkbox"/> Commercial Salad Dressings w/ Oil <input type="checkbox"/> Commercial Peanut Butter (i.e. Jiff)
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Name: \_\_\_\_\_

Date: \_\_\_\_\_

### List of Medications and Supplements

Please list all **nutritional and herbal supplements** and dosage(s) you are currently taking or have taken in the past 6 months (for additional space use the back):

1. \_\_\_\_\_ amount \_\_\_\_\_ frequency \_\_\_\_\_
2. \_\_\_\_\_ amount \_\_\_\_\_ frequency \_\_\_\_\_
3. \_\_\_\_\_ amount \_\_\_\_\_ frequency \_\_\_\_\_
4. \_\_\_\_\_ amount \_\_\_\_\_ frequency \_\_\_\_\_
5. \_\_\_\_\_ amount \_\_\_\_\_ frequency \_\_\_\_\_

Please list all **prescription and over the counter medicines** and dosage(s) you are currently taking or have taken in the past 6 months (for additional space use the back):

1. \_\_\_\_\_ amount \_\_\_\_\_ frequency \_\_\_\_\_
2. \_\_\_\_\_ amount \_\_\_\_\_ frequency \_\_\_\_\_
3. \_\_\_\_\_ amount \_\_\_\_\_ frequency \_\_\_\_\_
4. \_\_\_\_\_ amount \_\_\_\_\_ frequency \_\_\_\_\_
5. \_\_\_\_\_ amount \_\_\_\_\_ frequency \_\_\_\_\_

Please list any known allergens: \_\_\_\_\_  
\_\_\_\_\_

Circle the TRUE or FALSE answer that best describes you:

- |  |       |      |
|--|-------|------|
| 1. Appetite at breakfast is strong.....  | FALSE | TRUE |
| 2. Appetite at lunch is strong .....   | FALSE | TRUE |
| 3. Appetite at dinner is strong .....  | FALSE | TRUE |
| 4. Eating before bedtime improves my sleep.....  | FALSE | TRUE |
| 5. I live to eat not to subsist .....  | FALSE | TRUE |
| 6. Often I get hungry between meals .....  | FALSE | TRUE |
| 7. Fruits generally do not agree with me.....  | FALSE | TRUE |
| 8. Fasting makes me feel awful.....  | FALSE | TRUE |
| 9. I crave salt .....  | FALSE | TRUE |
| 10. Orange juice in the morning does not agree with me .....                               | FALSE | TRUE |
| 11. A meal heavy with fat agrees with me .....   | FALSE | TRUE |
| 12. Going without food for 4 hours is uncomfortable.....                                   | FALSE | TRUE |
| 13. I do not care for sweet desserts .....   | FALSE | TRUE |
| 14. Vegetarian meals are not satisfactory to me .....                                      | FALSE | TRUE |
| 15. Protein for breakfast makes me more energetic (meat, fish, beans, tofu, poultry) ..... | FALSE | TRUE |
| 16. Protein for lunch makes me more energetic (meat, fish, beans, tofu, poultry).....      | FALSE | TRUE |
| 17. Protein for dinner makes me more energetic (meat, fish, beans, tofu, poultry).....     | FALSE | TRUE |
| 18. Eating protein foods restores my energy (meat, fish, beans, tofu, poultry).....        | FALSE | TRUE |

TYPE OF METABOLISM: \_\_\_\_\_ (for office use only) TOTAL: \_\_\_\_\_

## Diet Diary / Exercise Log

<b>Day</b> __	Date:
Wake up time:	
Morning Meal	
Time:	
Snack Time:	
Mid-Day Meal	
Time:	
Snack Time:	
Evening Meal	
Time:	
Snack Time:	
Water	
(Ounces)	
Other Drinks  (that are not listed with meals or snacks above)	
Activity/Exercise What kind:	
How Long:	
Relaxation Type: How Long:	
Sleep Time:	
Rx Medications:	

Name \_\_\_\_\_

Please Complete your  
"Diet Diary/Exercise Log"  
everyday.

1. Make note of the time you wake up

2. List and describe in detail all foods and drinks including the amount of each. Make note as to whether the food was fresh, frozen, canned, raw, cooked, baked, fried, etc. Note the time of each meal or snack. Be sure to list everything you eat or drink, including any condiments used (i.e. mayonnaise, mustard relish, etc.).

3. Keep track of how much water you drink and list the amount in ounces in the section provided. Also note the type and amount of any other drinks you consume.

4. Write down any activity or exercise you do in the section at the bottom, listing the kind of exercise you did and for how long you did it.

5. Note any periods of relaxation and what kind of relaxation it was.

6. Note the time you go to sleep.

## Authorization for the Release of Information

I, the patient, hereby authorize the use or disclosure of my health information from the listed Health practitioner as described below to the requesting practitioner.

---

### Patient Information

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone \_\_\_\_\_ Social Security Number \_\_\_\_\_

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### Health Practitioner 1

Health Practitioner Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone \_\_\_\_\_ Fax Number \_\_\_\_\_

---

I authorize for Morgan Mellas Telor to release and/or disclose the medical information as indicated below to the health care provider, entity, or person I have indicated above.

**DURATION:** This authorization shall become effective immediately and shall remain in effect until \_\_\_\_\_(date), or for one year from the date of signature if no date entered.

**REVOCATION:** This authorization may be revoked in writing by the undersigned at any time prior to the release of information from the disclosing party. Written revocation will not affect any action taken in reliance on this authorization before the written revocation was received.

### Check the box and initial which type of information is to be released and/or disclosed:

€ \_\_\_\_\_ General Medical Information from \_\_\_\_\_ to \_\_\_\_\_ (dates)

€ \_\_\_\_\_ Laboratory Tests (serum, urine) from \_\_\_\_\_ to \_\_\_\_\_ (dates)

€ \_\_\_\_\_ Information regarding specific diagnosis or treatment from \_\_\_\_\_ to \_\_\_\_\_.

€ \_\_\_\_\_ Other Nutrition and Dental \_\_\_\_\_

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### Requesting Practitioner Information

Morgan Mellas Telor, Nutrition Healing

Berlin Wellness Group

6221 Wilshire Boulevard, suite 518

Los Angeles, CA 90048

Ph: 818-742-1496 Fax: 323-549-0440

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Patient Name (printed): \_\_\_\_\_

Signature of Patient \_\_\_\_\_ Date: \_\_\_\_\_

**ALL PATIENT INFORMATION IS HANDLED UNDER THE HIPPA PRIVACY ACT  
CONFIDENTIAL / HIPPA Approved Form**

Name: \_\_\_\_\_

Date: \_\_\_\_\_

# RECOMMENDED NUTRITIONAL LABS

Physician \_\_\_\_\_

- Please have the marked blood labs completed and the results sent with this packet unless they have been completed in the last 6 months. These labs must be requested through your physician.
- If the labs were completed in the last 6 months, request copies of the results from your healthcare practitioner and send with this packet or have your healthcare practitioner fax the results to Morgan Mellas Telor, Fax 323.549.0440.

**The labs are used for a more complete monitoring and assessment of Nutritional Healing.**

### Serum Labs:

- Hemoglobin/Hematocrit
- MCV
- MCH
- Ferritin (storage iron)
- Vitamin B12
- Folate
- Homocysteine
- CBC with Electrolytes & CO2
- Differential
- Magnesium
- Zinc
- Iron Panel: Serum Iron, TIBC, Iron Sat%

### Dysglycemia Status:

- Glucose: (fasting) / random
- Insulin: (fasting)
- Hemoglobin A1C
- Other: \_\_\_\_\_

### Gastrointestinal Dysbiosis Panel

- Parasitology/ O&P \_\_\_\_
- Fungi/Yeast /Candida
- Bacteria \_\_\_\_\_
- Comprehensive Digestive Stool Analysis (GSDL)

### Immunology (serum)

- Food Allergies IgE/IgG
- AntiGliadin
- Other: \_\_\_\_\_

### C-Reactive Protein (ultra sensitive/Cardio)

ESR/Sed Rate

Fibrinogen

Urinalysis

Other: \_\_\_\_\_

### Liver Function:

- Liver enzymes \_\_\_\_\_
- Bilirubin, direct + total
- Cholesterol Fasting? yes no
- HDL / LDL / VLDL
- Triglycerides
- Lipo (a)
- Other: \_\_\_\_\_

### Thyroid Status

- TSH
- Free T3
- Reverse T3
- Free T4
- Anti-TPO / Anti-TG Antibody Titer

### Kidney Function:

- BUN
- Creatinine
- GFR

### Protein Status

- Albumin
- PreAlbumin

### Endocrinology Women: blood/saliva

- E1 – Estrone
- E2 – Estradiol
- E3 - Estriol
- Progesterone
- Testosterone
- DHEA-S

### Endocrinology Men: blood/saliva

- Testosterone
- DHEA
- PSA
- Vitamin D 25 Hydroxy