



Patty Murphy, MS, CNS
Nutritionist
Plate Journey Nutrition

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www.platejourney.com

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	\$45.00
3 visit program – Initial individual consultation plus 3 follow-up consultations	\$220.00
Couples initial consultation	\$150.00
Couples Follow-up Consultations	\$65.00
Each Referral to friend or family	1 Free follow-up visit
Hours for Consultations: (by appointment)	

Payment is expected at the time of service in the form of cash or personal check. PayPal payments are also accepted through my website prior to your consultation. 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 in my home office – 11725 Duanesburg Road, Delanson, NY 12053 – or at your home (travel fee applies). 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

"The part can never be well unless the whole is well."
Plato

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
<i>Breakfast</i>		
<i>Morning Snack</i>		
<i>Lunch</i>		
<i>Afternoon Snack</i>		
<i>Dinner</i>		
<i>Evening Snack</i>		

[illegible]

Health History

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☐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

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Please check any conditions or symptoms you have now.

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Liver/Gall Bladder Disease | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Food Allergies, _____ | | <input type="checkbox"/> Diverticulitis | <input type="checkbox"/> Chronic Fatigue |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Hypothyroid | <input type="checkbox"/> Respiratory Allergies | <input type="checkbox"/> IBS |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Chronic Pain Condition | <input type="checkbox"/> PMS/Menopause | <input type="checkbox"/> 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 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.

- | | | | |
|--|--|---------------------------------------|--|
| <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Heart Disease _____ | <input type="checkbox"/> Stroke _____ | <input type="checkbox"/> High Blood Pressure _____ |
| <input type="checkbox"/> Allergies _____ | <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Asthma _____ | |
| <input type="checkbox"/> Other _____ | | | |

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

- | | | | |
|--|--|---|---------------------------------------|
| <input type="checkbox"/> Poor Appetite | <input type="checkbox"/> Poor Sleeping | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Night Sweats |
| <input type="checkbox"/> Cravings | <input type="checkbox"/> Poor Balance | <input type="checkbox"/> Weight loss/gain | <input type="checkbox"/> Fatigue |

Skin and Hair

- | | | | |
|--|---|---------------------------------------|---|
| <input type="checkbox"/> Rashes/Dermatitis | <input type="checkbox"/> Eczema/Psoriasis | <input type="checkbox"/> Loss of hair | <input type="checkbox"/> Weak or ridged nails |
|--|---|---------------------------------------|---|

Head, Eyes, Ears, Nose and Throat

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> Migraines | <input type="checkbox"/> Earaches |
| <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Poor hearing | <input type="checkbox"/> Spots in front of eyes | <input type="checkbox"/> Sinus problems |
| <input type="checkbox"/> Post nasal drip | <input type="checkbox"/> Headaches | | |

Cardiovascular

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Chest pain or pressure | <input type="checkbox"/> Irregular heart beat | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Dizziness | | |

Respiratory

- | | | | |
|---|---|---------------------------------|-------------------------------------|
| <input type="checkbox"/> Cough/Wheezing | <input type="checkbox"/> Hay Fever / Rhinitis | <input type="checkbox"/> Asthma | <input type="checkbox"/> Bronchitis |
| <input type="checkbox"/> Frequent Colds | <input type="checkbox"/> Smoking - current smoker <input type="checkbox"/> ; past smoker <input type="checkbox"/> | | |

Gastrointestinal

- | | | | |
|---|---|--|---------------------------------------|
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Gas | <input type="checkbox"/> Indigestion | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Bloating |
| <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Acid reflux/GERD | <input type="checkbox"/> IBS/Crohn's Disease | |

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