

Joyful Beginnings Midwifery

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Informed Disclosure for Midwifery Care

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As a parent, you are ultimately responsible for your birthing experience, regardless of where or with whom you give birth. Therefore, I encourage you to seriously consider the environment for birth and the caregivers whose services you choose. In Kentucky, your choices include obstetricians, family practitioners with hospital OB privileges, certified nurse-midwives (CNM), licensed, certified professional midwives (LCPM), and independent, non-regulated birth attendants. Each has a specific approach toward birth. Educate yourselves and ask questions. Contact childbirth consumer groups and find out what resources they may have to offer. Explore ALL your options so that your choices will be right for you. In Kentucky, parents have the right to birth how and where they choose, whether it be hospital or home.

Tracey Moore, LCPM

After years of self-study and welcoming many of my children, initially at a hospital, and then at home, I began apprenticing and working with other midwives in early 2004. I had my first client as a primary midwife in 2005, and I have now been the primary care provider for over 1100 births. I prefer to work in the area of natural, normal birth at home, not in “medical” situations.

My education and training have been primarily in the area of direct-entry midwifery in a home birth setting. I have had many years of self-study, periods of apprenticeship assisting in a home birth setting and a clinical internship in a free-standing birth center, all with direct-entry midwives. In addition, I pursue both voluntary and required continuing education every year. I have also occasionally worked in a hospital environment supporting birthing women. This has given me a valuable perspective on the use of medical assistance and intervention, and policies of some local hospitals. I am a Certified Professional Midwife (CPM) through the North American Registry of Midwives (NARM). *You can find out more about the CPM credential at www.mana.org.* I am also a licensed midwife in the state of Kentucky (LCPM), and I am certified in both CPR for adults and children, and Neonatal Resuscitation (NRP). I participate in peer review through a Kentucky midwives’ group, as well as with other groups of midwives from all over the US.

Renée Rojas, LCPM

I am an LCPM and have attended over 500 births. I myself was born at home and am one of 14 children in my family. My mother has helped women with childbirth for many years, and as a result I was introduced to birth work at a young age. In my late teens I worked short term on a mission in the Philippines, which greatly increased my interest. After graduating in 2001, I began serious study in midwifery along with helping my family at home. In 2008 I assisted with a few births and worked as a volunteer for a short time in a hospital in Jerusalem and Bethlehem, Israel. I then spent two years apprenticing in Missouri and in 2012-2013 I completed my training with Tracey in Kentucky and became a CPM. Tracey and I continued to work together in partnership through the end of 2017. I then moved to Georgia in January of 2018 to work on relationships with my family. In 2020 I received my Kentucky license and have continued to work/assist in Kentucky from time to time. I am now a practicing midwife in Georgia, though I continue to assist Tracey with office work virtually and phone calls/online contacts as well. We continue to support and consult with one another and share the practice name.

Philosophy of Practice

Our philosophy of practice is to support the rights of mothers to birth how, where, and with whom they choose. We believe that birth is a normal, natural process designed by God to work well. We believe that women have the right to competent midwifery care in their own home environment. We feel that it is our responsibility to give information, guidance, and support. Equally, the client seeking a home birth must accept full responsibility for the health care of herself and that of her baby. She must be honest with us, her caregivers, and cooperate to the best of her ability to ensure the best possible care during her pregnancy and birth. Childbirth carries risk to mother and baby, no matter the place of birth. However, all evidence available shows that home birth has equal or better outcomes than hospital-based care for normal, low risk pregnancies. Medical care is often fear-based, while midwifery care is most often faith-based. In almost every circumstance, we have complete faith in your body's ability to birth your baby. And in every circumstance, we believe that your birth will unfold in the way God meant it to. This does not mean we can guarantee a birth at home, but that we will do our best to support each client in the safest place for her baby to be born.

During the prenatal period, we will discuss and form an emergency care plan (or medical back-up plan). Each client's plan will be contingent upon the specific circumstances involved, her geographic location, and the available care providers and medical facilities in that area. If unforeseen circumstances arise, it may become necessary to transfer to a nearby medical facility for clinical care. We will recommend transfer when we feel that complications are developing that should not be handled at home or are outside the scope of our care. Transporting by private car may be the best option available if it becomes necessary to transfer mother and/or baby from home.

Whenever possible, all procedures will be done with the client's consent. Procedures will be described in detail, as well as their expected benefits and risks. Possible alternative procedures will be discussed, as well as their expected benefits and risks, apart from a life-threatening emergency in which we do not have time to discuss options. If the client and her partner choose to refuse a recommended action, they will be asked to sign an 'informed consent and refusal' form. Any treatment or procedure required by law that is refused by the client will necessitate that the client sign an 'informed consent and refusal' form.

In our practice, our goal is to be a good match to each client so that developing good relationships comes naturally. The relationship between midwife and client is a mutual one. Both are required to carry an equal share of responsibility. Therefore, we feel it is imperative that we outline responsibilities before entering this relationship. If the client fails to meet her responsibilities, we reserve the right to discontinue care.

Confidentiality and Protected Health Information

By hiring Joyful Beginnings Midwifery, you authorize your midwives to have full access to your medical records and Protected Health Information (PHI). Joyful Beginnings Midwifery will use and disclose to its staff and partners your PHI to carry out treatment, payment, or healthcare operations (TPO) related to your care. This information may include medical consultations, referrals, test results or ultrasound orders. All reasonable steps will be taken to protect your privacy and health information. You must give us specific authority to disclose any information to your family or support person.

Client has the right to:

- Request access to her health records at any time.
- Request corrections to be made to her health record. Requests must be made in writing. Midwife reserves the right to deny these changes.
- Request that all communications regarding her care with Joyful Beginnings Midwifery be restricted from unsecure transmissions (fax, email, voice mail, Facebook messaging). If client uses these methods of communication, client is giving permission for midwife to reply in the same way.
- Complain about a perceived violation of her privacy to us, our certification board, or the US Office for Civil Rights.

Client understands and agrees that:

- Students who are involved in her care may access her records and use her records, with all identifying information removed, for their educational portfolios.
- Midwives, students, and assistants may discuss her care and treatment (non-identified) with colleagues as part of peer review.
- Midwife may disclose health information if required to by law, or in cases of abuse or neglect where it appears there is a genuine threat to mother or baby's health or safety.
- Joyful Beginnings may use video, audio, or photographic methods at appointments or birth, for the purpose of charting and review, not to be shared outside of the practice without permission.
- Joyful Beginnings may use photos, baby's first name, statistics and footprints for client's own use, or in office, social media or for educational purposes. (I trust my midwife's judgement of what is modest and appropriate for myself and my community. I have the right to request removal of photo or video at any time, now or in the future.)
- Client has the right to request that restrictions be placed on the use and disclosure of her health information, however, if the midwife feels the information is relevant to care of the client or baby, she may refuse.

Joyful Beginnings Midwifery has permission to disclose protected health information to the following family members or caregivers:

Client Consent:

By signing below, the client confirms that she, freely and of her own will, chooses to labor and give birth out-of-hospital. The Client understands that, although her safety and that of the baby is always the midwife's priority, absolute safety cannot be guaranteed. Client understands that risk is a part of life, including childbearing, regardless of the location of labor and birth.

Client understands that:

1. Certain risks may be greater in the hospital setting such as unwanted interventions and/or interference with the normal birth process which could lead to unnecessary surgery, hospital-acquired infections, drug/anesthetic reactions, medication errors, and other potentially avoidable complications.
2. Certain risks may be greater in the out-of-hospital setting such as less access to certain treatments and a delay in emergent treatment in the event of rare, but potentially life-threatening circumstances such as severe fetal distress, cord prolapse, placental abruption, uterine rupture, or other possible emergent surgical need.
3. Complications, including emergencies, may be unforeseen and can suddenly arise which may present a hazard to herself and her child.
4. Although the midwife has emergency management training and carries equipment for resuscitation and other emergencies, some complications are best handled in a hospital setting where additional personnel, equipment, diagnostic services, and therapeutic measures are available.
5. Joyful Beginnings does not carry professional malpractice insurance.

Midwife's responsibilities include:

1. Keeping lines of communication open.
2. Nurturing a relationship of mutual trust and respect.
3. Providing the best care possible according to our guidelines and our best knowledge and judgment.
4. Being honest about our experience and comfort level in dealing with arising situations.
5. Giving information and informed consent.
6. Referring client or consulting when necessary.
7. Being reasonably available.

Client's responsibilities include:

1. Responsibility for the consequences of the decision to have a planned out-of-hospital birth.
2. Keeping lines of communication open.
3. Nurturing a relationship of mutual trust and respect.
4. Staying as healthy as possible, following the guidance and suggestions of the midwife.
5. Having confidence in her body's ability to birth her baby. This is not something the midwife can do for her. She must commit herself.
6. Being flexible about appointment days and times, especially when the midwife travels to her. Other babies will come on their own schedules, and the midwives' families have needs too.
7. Paying the midwife in a timely manner and honoring the pre-arranged financial agreement. This shows the midwife that she is respected, and that the client values her time and services.
8. Client will not attempt to induce labor without collaboration and prior agreement with midwife.

Transport/Transfer Agreement

If, at any time, the midwife advises that the situation requires consultation, referral or hospital transfer, the client and her partner consent to an emergent or non-emergent transport at the client's discretion, admission to an appropriate medical facility, and transfer of care to the receiving physician/personnel.

Insurance Coverage

The client is responsible for payment to her midwife and may then obtain reimbursement from her insurance company. We do not deal directly with insurance companies and clients are responsible for filing their own claim for reimbursement. If the client's insurance company does not fully cover the charge or does not reimburse according to her expectations, the client is still responsible for the full fee.

By signing below, the client and her partner confirm that they have read and understood the content of this form. They have considered all available birth options and freely choose to have Tracey Moore and the staff of Joyful Beginnings Midwifery at the birth of their child at home. It is the client's right and responsibility to ask questions if she does not fully understand any aspect of the care she has chosen to receive. It is the client's right and responsibility to seek medical or hospital care if at any time she is concerned about her well-being or that of her baby.

Client Signature

Date

Client Printed Name

Partner Signature

Date

Partner Printed Name

Joyful Beginnings Midwifery, LLC

Date

Joyful Beginnings Midwifery, LLC

Tracey Moore, LCPM

Financial Commitment

I consider it a special experience to assist in the birth of your child. It is also a demanding commitment to provide quality midwifery services. I am usually on call 24 hours a day, 7 days a week, all year long. When on call but personally unavailable, I am paying a backup midwife to cover for me. In order to provide personal, experienced and knowledgeable care, it is essential that the cost of my work as well as all of the associated equipment and business costs are paid for. This agreement between us covers your financial commitment to pay the cost of the care we provide.

I charge \$_____ for my services. This fee includes prenatal care, home visits, attendance at your birth, an assistant if I deem it necessary, phone consultations, and postpartum visits. You are also responsible for the cost of supplies, lab work, ultrasounds, Rhogam (if you are Rh-), newborn screening, and any CNM, physician, or hospital care needed. There are no additional facility fees or hidden charges. I pay my assistant or apprentice as is appropriate, but if you feel they do a good job, a tip or small gift to them is always welcome. If your situation becomes higher risk (i.e., twins, breech etc.), there will be additional fees to cover additional caregivers and costs. Excessive communication demands outside of your scheduled visit times may incur additional costs which you will be advised of prior to being billed.

The cost for services includes a \$400.00 non-refundable retainer to secure your place with our practice. If you choose to leave our practice for any reason before 36 weeks, this retainer plus the cost per visit provided up to that point cannot be refunded. Missed visits will also be billed at \$150.00 unless rescheduled beforehand and in a timely manner. If leaving our care requires additional assistance, that time may also be billed.

The full fee for services is due by your 36th week of pregnancy. Any payment after this date must be agreed to in advance. Prior to your 36th week, you can set up a payment plan that works best for you. I recommend making a payment at each prenatal visit – the average prenatal care consists of about 6-10 prenatal visits over 6-7 months of pregnancy. If you have any unforeseen financial issue, please contact me as soon as possible.

If transport to the hospital becomes necessary, I will continue to provide care personally or through an assistant, student, or doula if able. I often work harder for clients with transports than for those that birth at home. I will do my best to ensure that you have the safest birth possible, wherever that needs to take place. Please remember that the cost of the care provided is not determined by where the birth takes place and a birth outside of the home does not entitle you to a refund.

If your primary midwife is unable to attend your birth due to attending another birth, illness, injury, distance or other cause, every effort will be made to arrange for a backup midwife. Attendance by a backup midwife will be considered equivalent to having the primary midwife attending the birth. If the midwife is unable to attend your birth through no fault of our own (rapid labor, failure to notify us of labor, weather conditions) the cost of care is still due.

If your birth plans change during the last trimester, but before 36 weeks, refunds may be given for payments made in excess of the value of care already provided, at my discretion. If your birth plans change after 36 weeks, either by necessity or by choice, the full fee is due.

If you decide, by necessity or choice, to leave my care and have a hospital birth, I am available to provide supplementary services or postpartum care as you may request. I am always available for questions by phone, before or after the birth.

Individual Financial Agreement

We agree to pay \$ _____, per month, on the 1st of each month to Joyful Beginnings Midwifery towards the midwifery care to be provided during pregnancy and for the birth of our child with the first payment due: _____. Paid in full by: _____.

Agreed Payment Plan: _____

We have read the above information and understand our financial responsibilities. We understand that Joyful Beginnings Midwifery relies on our timely payments to cover their costs and provide care. If any agreed upon payment is not made on time a \$25.00 missed payment fee will be applied. Client and Partner are together and each individually responsible for all amounts owed. If collection of any outstanding balance becomes necessary, we will pay the cost of collection including court costs and attorney fees. Any dispute arising out of this agreement must be submitted to mediation prior to filing suit with the cost of mediation shared between the parties.

Client Signature

Date

Client Printed Name

Partner Signature

Date

Partner Printed Name

Joyful Beginnings Midwifery, LLC

Date

Medical History

Joyful Beginnings Midwifery

This form is to be filled out by the mother. Please answer all questions to the best of your ability. The information you provide will help us give you better care.

Today's date: _____

Basic Information

First name: _____ Middle name: _____ Last name: _____ Maiden name: _____

Preferred name: _____ Birth date: _____ State/country of birth: _____

Social security number: _____ Are you married? _____ Nationality: _____

Are you of Hispanic origin? _____ Occupation: _____ Employer: _____

Religion: _____ Highest level of education: _____ Degrees: _____

Do you have a living will? _____ Are you an organ donor? _____ Email: _____

Street address: _____ City: _____ State: _____ Zip code: _____

County: _____ Home phone: _____ Cell phone: _____

Is your address within city limits? _____ Who referred you to our services? _____

Is there any route you would like us NOT to contact you for reminders or follow-ups? Y / N _____

Emergency contact: _____ Phone number: _____ Relationship: _____

Payment type: _____ (cash/check) Do you receive WIC? _____ Are you eligible for Medicaid? _____

Current Pregnancy

Last normal period: _____ Conception date if known: _____ Ovulation date: _____

Have you heard baby's heartbeat? When? _____ Have you felt your baby move? When? _____

Planned delivery site: _____ Pre-pregnancy weight: _____ Baby's gender (if known): _____

Baby's name (if known): _____ Pediatrician name and phone #: _____

How do you feel about this pregnancy? _____

How does the baby's father feel? _____

Have you had any prenatal care before now? _____ Name of provider: _____ How many visits have you received from other provider? _____ When was your first visit? _____ Last visit: _____

Have you had any emotional or sexual problems with your marriage while pregnant? _____

What are your main reasons for wanting to have this baby at home? _____

How does baby's father feel? _____

Are any of your family or friends very against you having your baby at home? _____

Having your baby at home is no guarantee that things will go perfectly. If you are a low risk woman, the chance of unpredictable complications is low. However, if such a complication should occur, you or your baby may be at greater risk if you are not in the hospital. Do you have any particular concerns about complications and how they might be handled?

If we felt that complications were arising, how would you feel about transporting to the hospital? _____

Who do you plan to have at your birth? _____

Do you plan to breastfeed? How long? _____ Do you plan to circumcise your baby if it is a boy? Why or why not? _____

What do you see as the duties of your midwives? Is there anything in particular that you want us to do or not to do? _____

How do you heat your home? _____ If you do not have a phone, how close is the nearest available phone? _____ Is your water safe to drink? _____ How do you feel about gaining weight in pregnancy? _____ Have you ever had any problems with eating too much or not enough (anorexia/bulimia)? _____

Have you had any birth classes? When and where? _____

Are you interested in having a water birth? _____ Would you like more information? _____ Do you have plans for your placenta? _____ Do you have any other birth or postpartum preferences? _____

Is there anything unusual we need to know about your home or pets? _____

Do you have WiFi in your home? _____ What is your WiFi password? _____

Will a GPS take us to your home or are there any other special directions that we need to know? _____

Have you had any of the following problems during *this pregnancy*?

Abdominal/pelvic pain	Backache	Bleeding gums	Constipation	Depression
Diarrhea	Dizziness	Fever	Headache	Hemorrhoids
Indigestion	Infections	Leg Cramps	Loneliness	Nausea
Relationship issues	Rash	Swelling	Urinary complaint	Vaginal bleeding
Vaginal discharge	Vomiting	Varicose veins	Work problems	Other

Please describe any problems and indicate when they began and when they resolved if not current: _____

Have you been exposed to any of the following during *this pregnancy*?

Abuse	Alcohol	Caffeine	Cats	Chickenpox
Cocaine	Fifth's disease	Fumes/Sprays	Herbs	Marijuana
Measles	OTC drugs	Prescription drugs	Street drugs	Tobacco
Trauma	Ultrasound	Vaccinations	Viruses	Vitamins
X-rays	Other			

Comments: _____

Your Mother's History

How many times was your mother pregnant? _____ How many live births did she have? _____ How many miscarriages did she have (if any)? _____ What were her labors like? Were her babies late or early? Did she have any significant complications? _____

What was your birth weight? _____ Were you breastfed? How long? _____

Father of Baby

First name: _____ Middle name: _____ Last name: _____ Suffix: _____

Birthdate: _____ Phone number: _____ Email: _____

Is his address the same as yours? _____ Can we share your medical information with baby's father? _____

Are you married to baby's father? _____ Social security number: _____

State/Country of birth: _____ Nationality: _____ Is baby's father of Hispanic origin? _____

Occupation: _____ Employer: _____ Religion: _____

Highest level of education: _____ Degrees: _____ Blood type: _____ Birth weight: _____

Father of Baby's History

Has the baby's father ever had any of these conditions?

Alcohol/Drug Abuse Severe Emotional Problems STD Tobacco Use Urethritis

Other medical conditions: _____

Genetic History

Have either you or the baby's father ever had a baby with birth defects? Y/N _____

Did you or father of baby have a birth defect yourself? Y/N _____

Does the father of baby have a history of pregnancy losses with another partner (miscarriages or stillbirths)? Y/N _____

Have either of you had genetic counseling or chromosomal studies? Y/N _____

Are you or father of baby of Jewish ancestry? Y/N _____ Are you or father of baby black? Y/N _____

Will you be 35 or older when baby is born? Y/N _____ Will father of baby be 50 or older when baby is born? Y/N _____

Do you have any objections to receiving blood or blood products? Y/N _____

Have you or father of baby ever had hepatitis or jaundice? Y/N _____

Have you or father of baby ever done illegal drugs? Y/N _____

Have you or father of baby ever had a blood transfusion? Y/N _____

Have you ever been told you use alcohol or drugs excessively? Y/N _____

Do you feel you are at increased risk of AIDS/HIV or hepatitis because of history or profession? Y/N _____

Past Pregnancies

Please record all previous pregnancies and births. Put an * before miscarriages/abortions. Include baby's name, date of birth or miscarriage/abortion (month/year), weeks' gestation, length of labor, weight, and where birth occurred. Add any other complications, pregnancies, and notes to back as needed. Please also indicate if each child is still living.

Baby's name	Birth date	Gestation	Length of labor	Baby's weight	Place of birth
1. _____					
Complications	_____				
2. _____					
Complications	_____				
3. _____					
Complications	_____				
4. _____					
Complications	_____				
5. _____					
Complications	_____				
6. _____					
Complications	_____				
7. _____					
Complications	_____				
8. _____					
Complications	_____				
9. _____					
Complications	_____				

Your Family History

Has anyone in your immediate family or father of baby had these conditions?

- | | | | | |
|--------------------|---------------------|---------|--------------------------|-----------------|
| Alcohol/drug abuse | Blood clots | Cancer | Congenital abnormalities | Diabetes |
| Heart disease | High blood pressure | Strokes | Mental illness | Thyroid disease |
| Twins | Down’s syndrome | Other | | |

Please add descriptions and family members and indicate when they began and when they resolved if not current: _____

Your Health

Your height: _____ Blood type: _____ Have you received Rhogam with previous pregnancies? _____

Have you *ever* had any of these conditions:

- | | | | | |
|--------------------|---------------------|-------------------|-----------------------|-------------------------|
| Abuse | Aching joints | Anemia | Anorexia/Bulimia | Asthma |
| Bladder infections | Blood in stool | Bowel problems | Chicken Pox | Chronic renal disease |
| Colitis | Dental problems | Depression | Diabetes | Ear/hearing problems |
| Eating disorder | Eye/vision problems | Fractures | Gall bladder problems | Heart problems |
| Hemorrhages | Hemorrhoids | Hepatitis | High blood pressure | HIV antibody positive |
| Hospitalizations | Hypoglycemia | Kidney infections | Liver problems | Pelvic/back injuries |
| Rheumatic fever | Seizures | Severe headaches | Skin disorders | Severe emotional prob |
| Stomach problems | Suicide attempt | Thrombophilia | Thyroid problems | Toxic exposure |
| Tuberculosis | Ulcers | Urethral dilation | Varicose veins | Other medical condition |

Please add descriptions and indicate when they began and when they resolved if not current: _____

Have you had any surgeries? _____ List all surgeries: _____

Have you ever had any other serious injuries or broken bones? _____

Have you ever experienced difficulty with anesthesia? _____

Have you ever had a blood transfusion? _____ Have you ever had preterm labor? _____

Are you currently under the care of any other health practitioner? _____

Medications

What medications or supplements are you currently taking? Please list:

Medication/supplement	Date started	Dose	Frequency	Reason

Do you have any drug allergies? _____

Do you have any food allergies? _____

Do you have any allergies or reactions to latex? _____ Have you had Rubella (German measles)? _____

Did you receive immunization (shots) as a child? _____ Do you smoke? _____ Does anyone else in your home smoke anything? _____ Do they go outside to smoke? _____ Do you have a cat litter box in your home? _____

Life Style

Do you regularly consume any of the following?

Alcohol	Black tea	Caffeinated soda	Coffee	Energy drinks
Green tea	Herbs	Non-prescription vitamins	Tobacco	None

How would you describe your normal diet? _____

How many cups of water do you drink daily? _____ How do you exercise and how often? _____

What is your current stress level? High, medium or low? _____ What is your typical stress level? _____

Source of stress: _____ Are you being abused? _____ Do you have a history of being abused? _____

Do you feel unsafe? _____ Have you ever been forced to have sex, or been hurt in your private areas as a child or an adult? _____ Is this something we should talk about later or privately? _____

Gynecologic History

Age of first period: _____ Number of periods per year: _____ How many days (from the start of one to the start of the next), is your cycle? _____ How many days of bleeding do you usually have? _____ Is your flow light, medium or heavy? _____ Do you have bleeding between periods? _____ Do you have irregular periods? _____

Do you have painful periods? _____ When was your last pap smear? _____ Have you ever had an abnormal pap smear? _____ Have you ever had a mammogram? _____ Have you ever had a breast exam? _____ When was your last breast exam? _____ Was it normal? _____

Sexual History

How old were you when you first had intercourse? _____ Total number of partners: _____ Are you currently monogamous? _____ Do you have pain during intercourse? _____

Have you ever used birth control? _____ Recent birth control used: _____ Other types of birth control used in the past: _____ Any complications? _____

Have you ever had any of the following conditions?

- | | | | | |
|--------------------|---------------------|-----------------|-------------------|----------------|
| Abnormal bleeding | Bacterial vaginosis | Breast lumps | Breast surgery | Cervical polyp |
| Cervical surgery | Cervicitis | Chlamydia | Condyloma (warts) | Endometriosis |
| Fibroids | Gardnerella | Genital herpes | Genital sores | Gonorrhea |
| HPV – leep or cryo | Infertility | Oral herpes | Ovarian cysts | PID |
| Syphillis | Trichomonas | Uterine surgery | Yeast infection | Other |

Please describe any problems and indicate when they began and when they resolved if not current: _____

Nutrition Profile

Please record EVERYTHING you eat or drink for 3 days. Include approximate amounts as much as possible. Please do not try to eat extra well for this sheet – it is meant to truly help you check your own diet and see where you might need more of some foods.

Breakfast	Breakfast	Breakfast
Snack	Snack	Snack
Lunch/Dinner	Lunch/Dinner	Lunch/Dinner
Snack	Snack	Snack
Dinner / Supper	Dinner / Supper	Dinner / Supper
Snack	Snack	Snack