

**Documentation of Potentially Harmful  
Nutrition Information and/or Products  
(Confidential)**

***I. Background Information***

**Date of Incident:** \_\_\_\_\_ **Date of Report** \_\_\_\_\_

**Identification**

Name of Consumer/Patient (optional): \_\_\_\_\_

Age: \_\_\_\_\_ Sex: M F (please circle)

City (where occurred): \_\_\_\_\_

**Person Filing the Report**

Name and Credentials: \_\_\_\_\_

Address: \_\_\_\_\_

Daytime Phone # \_\_\_\_\_ Evening Phone # \_\_\_\_\_

***II. Diagnosis History***

1. Was the consumer/patient diagnosed with any specific disorder by a licensed health professional prior to this interaction with the questionable practitioner/salesperson?      YES      NO
2. If so, what were the credentials of the individual providing the diagnosis?
3. What was the diagnosis/complaint?

***III. Suspected Nutritional Misinformation/Harm***

1. Type of Harm: (Check all that apply)  
\_\_\_\_\_ physical      \_\_\_\_\_ emotional      \_\_\_\_\_ financial
2. Source of Nutritional Advice: (Circle all that apply)  
Chiropractor      Acupuncturist      Herbalist      Radio/Television  
Brochure/Magazine      Newspaper      Naturopathic Doctor      Medical Doctor  
Nurse      Pharmacist      Physical Therapist      Health Food Store  
Other: \_\_\_\_\_
3. What credentials were provided to the consumer/patient upon interaction with the questionable nutrition provider/salesperson?
4. Did the questionable practitioner/salesperson obtain:
  - a. a diet record/recall/history?      YES      NO
  - b. a medical history including past medical problems?      YES      NO
  - c. a list of current medications the consumer/patient is taking?      YES      NO

**IV. Type of Advice or Product**

1. What advice was given by the questionable practitioner/salesperson? (Attach additional sheet if needed).

2. Did the questionable practitioner/salesperson provide scientific tests or studies to support the advice/product? YES NO

If yes, what tests, studies or trials were provided?

3. Cite references(s) indicating why this advice, product or service is potentially harmful:

**V. Type of Harm Incurred/Treatment**

**1. Physical Side Effects/Harm Incurred:** (Circle all that apply)

- |             |             |                        |                      |
|-------------|-------------|------------------------|----------------------|
| Nausea      | Vomiting    | Stomach/Abdominal Pain | Diarrhea             |
| Dizziness   | Rash        | Itchiness              | Respiratory Distress |
| Sleepiness  | Insomnia    | Organ Failure          | High Blood Pressure  |
| Weight Loss | Weight gain | Headaches              | Death                |
- Other: \_\_\_\_\_

**2. Emotional Harm Incurred:**

- |            |         |           |       |            |
|------------|---------|-----------|-------|------------|
| Depression | Anxiety | Agitation | Anger | Other_____ |
|------------|---------|-----------|-------|------------|

**3. Financial Harm Incurred:**

- a. What was the cost of the services/product provided?
- b. Were these costs worth the results that were obtained? YES NO (please describe)

**VI. Quality of Treatment**

- 1. Was followup care provided? YES NO
- 2. Did this treatment help the consumer/patient obtain desired results? YES NO

Signature of Person Filing this Report\_\_\_\_\_

Signature of Consumer/Patient (optional)\_\_\_\_\_

**Please return form to:** MDA Legislative Chair, c/o AMP, 3319 Greenfield Rd, #321, Dearborn, MI 48120