healthful living

Last Name: _____

Adult Nutrition Intake

Name: _____ **Height:** _____ **Weight**: _____

Address: _____ **Date of birth:** _____ **Age:** _____

_____ **Blood type:** _____

Phone Hm: _____ **Referred by:** _____

Work _____

Cell: _____

E-mail: _____

Health Objectives

_____

_____

_____

_____

What would you like to learn and gain from working with a nutrition consultant? *(i.e. how foods affect an ailment, understanding of how the body works, lifestyle improvement, etc.)*

_____

_____

_____

_____

Health Background

Describe any current health conditions that you are interested in addressing (onset, duration, frequency, etc):

_____

_____

_____

_____

How have you addressed these conditions (currently and in the past) (doctor, self-care, nutrition, acupuncture) and what has been the impact (positive and/or negative)?

_____

_____

_____

Last Name: _____

Personal Health History

What practitioners are you currently seeing? May I contact them with your permission?

Name	**Specialty/condition**	**Phone**	**Permission**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

List Medications (include condition, i.e. *Zoloft for depression)*

_____ _____

_____ _____

List Supplements (or attach separate page)

Important: Include form, dosage, and frequency i.e. c*alcium citrate, 400mg twice/day*

_____ _____

_____ _____

_____ _____

_____ _____

Describe your health history as child *(*generally healthy, frequently sick, ear infections, etc.)

_____

_____

_____

Antibiotics: Describe how frequently you have taken antibiotics over the course of your life *(include long term use for acne, short term courses, etc.).*

_____

_____

Do you have the following feelings/symptoms, how often?

Spacey/fuzzy thinking _____

Allergies/runny nose _____

Eczema, rashes or skin conditions _____

Yeast overgrowth (yeast infections, nail fungus, athlete's foot) _____

Mood/Energy/Sleep

Fatigue _____

Depression _____

Anxiety _____

Stress level (1-10; 1 low and 10 high) _____

Occupation _____ Do you like your work? _____

How much sleep do you get _____
What time do you go to bed, to sleep, and wake up _____
Do you have trouble falling asleep _____
Do you wake in the night? What time? _____ Reason (i.e kids, mind)? _____
How long does it take to fall back asleep? _____

Body/Exercise

Recent weight changes (gained or lost)? _____
Do you want to change your weight? If so, how? _____
Amount/type of Exercise: _____

Women

Do you still have menstrual periods? _____
Number of days between cycles _____
Length of period _____
Are you pregnant? _____
Trying to get pregnant? _____
Nursing? _____
Number of children and ages _____
Do you have PMS, cramps, or any other imbalance? _____

Digestion and elimination

Do you have frequent gas or bloating? _____
Does gas have a strong odor? _____
Do you tend to have diarrhea or soft, unformed stool? _____
Do you tend to have constipation? _____
Do you have burping, heartburn or acid reflux? Do you take antacids or acid blockers? _____
_____
Describe any other digestive issues? _____
_____

How frequently to you have a bowel movement? _____

What is consistency of stool?
Formed like a brown banana _____
Unformed, soft, or ribbon-like _____
Small balls formed into banana, or “rabbit-pellets” _____
Large diameter or anything else unusual _____

Last Name: _____

Dietary History

Vegetarian (eat eggs and dairy) Yes / No _____
Vegan (No eggs or dairy) Yes / No _____
Eat fish? How often and what type? _____

Do you have any known food allergies or sensitivities? _____
Type of allergy testing (skin/scratch, IgE/IgG, muscle testing, dietary elimination)?_____
Do you get headaches, joint pain, gut or other pain? _____

Do you have any dietary restrictions _____

Do you have any food cravings (sugar, carbs, fats)_____

Do you consume: Coffee/caffeine ____ Diet sodas ____ Trans fats ____ Soda ____ MSG ____

How much water do you drink per day? _____ What type (tap, bottled, filtered) _____

Describe dieting history or eating disorders? *(i.e. Age, yo-yo dieting, calorie restriction, weight gain)*
_____

Have you been diagnosed or believe you may have hypoglycemia _____
Do you need to eat frequently? _____
Do you get irritable, dizzy, headaches when you go too long without eating? _____

Family History *(indicate family member or self)*

Diabetes/Hypoglycemia _____	Colitis/IBS _____
Heart Disease _____	Arthritis _____
Cancer _____	Autoimmune disorder _____
Obesity _____	Migraines/Headaches _____
Depression, anxiety _____	Alcoholism _____
ADHD, Autism, LD _____	Bipolar, schizophrenia _____
Hyperactivity, tics _____	Other _____

Toxic exposure:
Have you had exposure to any toxins (pesticides, chemicals, heavy metals, plastics, inhaled chemicals, industrial chemicals) that you are aware of at your home or office?

_____

Have you received any vaccinations including the flu shot in the last few years?

_____

Are there any chemicals or smells that you are sensitive to (headaches, nausea)?

_____

Have you recently remodeled or plan to remodel your home? What did you have done?

_____

Do you consume or have exposure to the following, explain frequency:

Artificial sweeteners _____
Fluoridated water _____
Chemical cleaning supplies_____
Perfume/fragrance _____
Fabric softener
or drier sheets _____
Tobacco _____
Alcohol /recreational drugs _____

Last Name: _____

Food/Mood Record

1. Please write out your daily diet. Fill out a diet record for at least two days. Include **portion size** and any **supplements or medications.** Include **time** of day.
2. Additionally, record any symptoms you feel during or after eating, such as drowsy, irritable, energized.

	Time	Food/Supplements	Mood/Energy/Symptoms
Example	*9:00*	*1 cup of Cheerios with 3/4 c cow milk* *1 multi-vit/min, 500 mg vit C*	*10:00 Feel fine* *11:00 Low energy, stressed*
Breakfast			
Snack			
Lunch			
Snack			
Dinner			
Night-time Eating			

How much and what type of beverages do you drink each day:

Water ____ Fruit juices (type) _____ Juice "drinks" _____

Milk ____ Soft drinks (sugar or diet) _____ Other _____

Last Name: _____

Food/Mood Record

1. Please write out your daily diet. Fill out a diet record for at least two days. Include **portion size** and any **supplements or medications.** Include **time** of day.
2. Additionally, record any symptoms you feel during or after eating, such as drowsy, irritable, energized.

	Time	Food/Supplements	Mood/Energy/Symptoms
Example	*9:00*	*1 cup of Cheerios with 3/4 c cow milk*	*10:00 Feel fine*
		1 multi-vit/min, 500 mg vit C	*11:00 Low energy, stressed*

Breakfast

Snack

Lunch

Snack

Dinner

Night-time Eating

How much and what type of beverages do you drink each day:

Water ____ Fruit juices (type) _____ Juice "drinks" _____

Milk ____ Soft drinks (sugar or diet) _____ Other _____

Last Name: _____

Nutrition Consultant Service Agreement

I, _____, am consulting with Julie Matthews, Certified Nutrition Consultant to gain information on health and wellness. I understand that Julie Matthews is not a physician and that she does not dispense medical advice nor prescribe treatment. Rather, she provides information to enhance my knowledge of how nutritious foods, herbs, supplements, and lifestyle affect my health.

Julie Matthews' training includes a two-year certification program in nutrition education and consultation from Bauman College in California. The methods of evaluation employed on my behalf, which may include diet, supplementation, and assessment analysis, are not intended to diagnose disease. I specifically authorize the use of such assessments to help develop an appropriate dietary and health-supporting program for me, and to monitor my progress towards achieving my health goals.

These services are not a substitute for medical care, and do not claim to diagnose, treat, or alleviate disease. Nutrition consultation services are not licensed by the state of California and they are alternative or complementary to the healing arts services licensed by the state. For medical diagnosis and treatment of disease, I would need to consult with a medical physician or other licensed healing arts practitioner.

I am acting solely on my own behalf. I do not represent any other person, entity, and/or governmental agency.

I currently am ___ am not ___ under the care of a physician for a health problem or medical condition. I give Julie Matthews permission to contact my physician, _____, at the following phone number _____ on my behalf. The purpose of this contact would be to attain additional information from my doctor on his/her diagnosis or recommended treatment, in order that Ms. Matthews may best provide me with appropriate and complementary information. I know that Julie is not, and cannot be, a primary healthcare provider.

I agree to hold Julie Matthews and Healthful Living harmless for any claims or damages in association with our work together. This is a contract between Julie Matthews/Healthful Living and myself and a general release of liability for Julie Matthews and Healthful Living.

I understand Healthful Living has a 48-hour cancellation policy, and am aware that I will be charged a $50 cancellation fee for a missed appointment if proper notice is not given (by phone NOT e-mail).

For prepaid and discounted Appointment Packages, unused portions are not refundable. It is highly recommended that Appointment Packages be fully utilized within 6 months of their original purchase date, as this best serves client and practitioner objectives for motivation and timely results. Portions of prepaid packages will be forfeited if unused after 9 months.

Signature: _____
Client Name: _____
Date: _____

{Please keep a copy for your records}