Last Name: _____

Nutrition Intake - Child

Child's Name: _____ **Height:** _____ **Weight:** _____

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

_____ **Blood type:** _____

Parent Name(s) _____ _____

Phone: Home _____ **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: _____

Child's 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 (include dosage, i.e. *Vit E, 400IU*)

_____ _____
_____ _____
_____ _____
_____ _____

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

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

_____
_____

Does your child have/get yeast overgrowth (yeast infections, nail fungus, athlete's foot) now or in past

_____

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

Fatigue _____
Allergies/runny nose _____
Eczema, rashes or skin conditions _____
Depression/anxiety _____

Digestion and elimination

Do your child have frequent gas or bloating? _____

Does gas have a strong odor? _____

Do your child tend to have diarrhea or soft, unformed stool? _____

Do your child tend to have constipation? _____

Do your child have heartburn or acid reflux? Do you take antacids or acid blockers? _____

_____

Describe any other digestive issues? _____

_____

How frequently does your child 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" _____

Dietary History

Does your child have any food cravings (sugar, carbs, fats)?

_____

Does your child have any known food allergies or sensitivities? _____

Does your child get unexplained headaches, diarrhea, pain, fuzzy thinking, fatigue?

_____

Does your child consume: Coffee/caffeine ___ Diet sodas ___ Trans fats ___ Soda ___ MSG ____

How much water do they 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 child been diagnosed or believe you may have hypoglycemia _____

Do they need to eat frequently? _____

Do they get irritable, nervous, dizzy, headaches, when you go too long without eating?

_____

Last Name: _____

Family History *(indicate family member, child, parent)*

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:

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

_____

Has your child received any vaccinations including the flu shot in the last few years?

_____

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

_____

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

_____

Does your child consume or have exposure to the following, explain frequency:

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

Last Name: _____

Food/Mood Record

1. Please write out you child's 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: _____

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Last Name: _____

Nutrition Consultant Service Agreement

On behalf of my child _____ 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 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 lab assessments, are not intended to diagnose disease. I specifically authorize the use of such assessments to help develop an appropriate dietary and health-supporting program and to monitor progress towards achieving my stated 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 healthcare practitioner.

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

My child currently is ❑ is not ❑ under the care of a physician for a health problem or medical condition. By providing the following information, I give Julie Matthews permission to contact his/her 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, LLC 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 12 months.

Signature: _____
Client Name: _____ for Child's Name: _____
Date: _____

{Please keep a copy for your records}