healthful living

Last Name: _____

Family Home Intake

Mother's Name _____ Phone (H) _____

Address: _____ Phone (W) _____

_____ Phone (C) _____

Mother's Email _____

Father's Name _____ Phone (H) _____

Address: _____ Phone (W) _____

_____ Phone (C) _____

Father's Email _____

Children	**Age**
_____	_____
_____	_____
_____	_____
_____	_____

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.)*

_____

_____

_____

_____

Last Name: _____

Home Cupboard Evaluation

Artificial sweeteners _____
High fructose corn sweetener _____
MSG _____
Artificial colors _____
Artificial Flavors _____
Preservatives _____
Soda _____
Trans fats _____
Fluoridated water _____
Chemical cleaning supplies_____
Perfume/fragrance _____
Fabric softener or drier sheets_____

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? _____

Do you have any dietary restrictions _____

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

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

What food does your family typically eat for:

Breakfast _____
_____

Lunch _____
_____

Dinner _____
_____

Snacks _____
_____

Drinks _____
_____

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 _____

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?

_____

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?

_____

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}