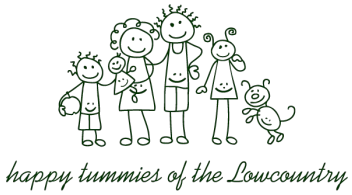

Initial Interview: Confidential Client Health Questionnaire

Consultation-Date: _____**Consultation Time:** _____

*** All of your personal information will remain strictly confidential! ****

Name: _____

E-mail Address: _____

Street Address: _____

City _____ State _____ Zip _____

Home Phone: _____ Work/Cell Phone: _____

Date of Birth: _____ Place of Birth: _____

Age: _____ Gender: _____ Height: _____ Current Weight: _____

Would you like your weight to be different? _____ If so, what? _____

Occupation: _____ How many hours do you work per week? _____

Relationship Status: _____ Children? _____

Blood Type (if known) _____ Referred by _____

Hobbies/Activities: _____

What are your health concerns? _____

_____

_____

_____

What would you like to accomplish/gain from this consultation? _____

_____

Do you sleep well? _____ Do wake up during the night?_____

If so, what time(s)? _____ What time do you go to bed? _____

What time do you generally wake-up?_____

How do you feel when you wake up? _____

Do you drink caffeinated drinks?_____ How much & how often? _____

Do you smoke? _____ How much & how often? _____

If no, why, how and when did you quit smoking? _____

Exposure to Secondhand Smoke? _____ If so, how and how long? _____

Do you drink alcohol?_____ How much & how often? _____

Do you drink soda (diet or regular)?_____ How much & how often? _____

What role does exercise play in your life? _____

Have you been exposed to toxic substances at work or home?

_____

How much water do you drink per day? _____

Do you have any allergies?_____

_____

_____

Are you currently taking any vitamins/minerals/herbs/homeopathic remedies, prescription/non-prescription medications, aspirin, laxatives, diet pills, or any other supplements? Please list all below including name brands and amounts:

_____

_____

_____

_____

Do you have any known allergies to medications or herbs? _____ Please list all: _____

_____

_____

Are you currently under a practitioner's care for a specific health issue? _____

If so, what treatments are you undergoing? _____

_____

_____

Please list any surgeries, accidents, injuries or childhood diseases you have had along with the type and date: _____

_____

_____

Have you had and dental procedures done i.e. fillings, root canals, pulled teeth, crowns, etc.?

_____

_____

What were your eating habits like as a child? (List types of foods) _____

_____

_____

What percentage of your food is home cooked?_____

How often do you eat out? _____

What are the three worst foods you eat each week?_____

_____

What are the three healthiest foods you eat each week?_____

_____

Do you crave sugar? _____ Do you crave salt? _____

Do you feel tired, bloated, and/or gassy after meals?_____

Do you experience constipation or diarrhea often? _____

When & how often? _____

_____

Do you feel excessively hungry?_____ Do you have a poor appetite?_____

Family Health History (Indicate Yes with a check mark)

Diabetes		Kidney disease		Asthma	
Heart Disease		Arthritis		Gallbladder disease	

Cancer		Type of cancer	
Stomach/Intestinal disorders		Other:	

Mother: Age:		Died from	
Father: Age:		Died from	

Maternal Grandmother: Age		Died from	
Paternal Grandmother: Age		Died from	

Maternal Grandfather: Age:		Died from	
Paternal Grandfather: Age		Died from	

WOMEN ONLY:

Age of your first period: _____ Are your periods regular?_____

How frequent? _____ # of pregnancies _____

How many days is your flow? _____

Do you experience PMS?_____ Is it mild or severe?_____

Are you peri-menopausal? _____ When did this change first occur? _____

Are you menopausal? _____ When was your last period? _____

List your symptoms of peri/menopause:_____

_____

_____

How many children have you delivered and how were they born (vaginally or by cesarean)? _____

_____

_____

Were there complications associated with these births? _____

Please explain: _____

_____

Did you receive antibiotics during labor?_____

Have you ever had a miscarriage or an abortion? _____ How many? _____

MALE ONLY

Approximate age of onset of puberty:_____ # of Children:_____

Do you feel your libido is adequate? Y N Comments:_____

Do you wake at night to urinate?_____ How many times per night?_____

Do you have any difficulty and/or pain with urination? Y N Diminished volume or flow? Y N

Do you enjoy daily activities? Y N Do you feel apathetic or complacent about previously enjoyed sports, hobbies, clubs, games, etc.? _____

Do you notices feeling more agitated/irritable than previously?_____

Do you feel less assertive in daily life than previously?_____

Would you like to discuss men's health issues specifically?_____

Food Journal

Name:_____ Date:_____

Write down everything you eat and drink for three days, including all snacks, beverages, and water. Please include approximate amounts. If you notice any mood or digestive changes associated with a meal/snack, record it in the right-hand column.		
Meal	**Beverages**	**Mood/Digestive Changes**
Breakfast (Time:_____)		
Snacks (Time:_____)		
Lunch (Time:_____)		
Snacks (Time:_____)		
Dinner (Time:_____)		
Snacks (Time:_____)		

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Food Journal

Name:_____ Date:_____

Write down everything you eat and drink for three days, including all snacks, beverages, and water. Please include approximate amounts. If you notice any mood or digestive changes associated with a meal/snack, record it in the right-hand column.		
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Food Journal

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Snacks (Time:_____)		
Dinner (Time:_____)		
Snacks (Time:_____)		

NUTRITIONAL THERAPY INFORMED CONSENT AND DISCLAIMER

_____, Nutritional Therapist
(Insert Name of NT)

Before you choose to use the services of a Nutritional Therapist, please read the following information **FULLY AND CAREFULLY.**

GOAL: Our basic goal is to encourage people to become knowledgeable about and responsible for their own health, and to bring it to a personal optimum level. Nutritional therapy is designed to improve your health, but is not designed to treat any specific disease or medical condition. Reaching the goal of optimum health, absent other non-nutritional complicating factors, requires a sincere commitment from you, possible lifestyle changes, and a positive attitude. A Nutritional Therapist is trained to evaluate your nutritional needs and make recommendations of dietary change and nutritional supplements. A Nutritional Therapist is not trained to provide medical diagnoses, and no comment or recommendation should be construed as being a medical diagnosis. Since every human being is unique, we cannot guarantee any specific result from our programs.

HEALTH CONCERNS: If you suffer from a medical or pathological condition, you need to consult with an appropriate healthcare provider. A Nutritional Therapist is not a substitute for your family physician or other appropriate healthcare provider. A Nutritional Therapist is not trained nor licensed to diagnose or treat pathological conditions, illnesses, injuries, or diseases.

If you are under the care of another healthcare provider, it is important that you contact your other healthcare providers and alert them to your use of nutritional supplements. Nutritional therapy may be a beneficial adjunct to more traditional care, and it may also alter your need for medication, so it is important you always keep your physician informed of changes in your nutritional program.

If you are using medications of any kind, you are required to alert the Nutritional Therapist to such use, as well as to discuss any potential interactions between medications and nutritional products with your pharmacist.

If you have any physical or emotional reaction to nutritional therapy, discontinue their use immediately, and contact your Nutritional Therapist to ascertain if the reaction is adverse or an indication of the natural course of the body's adjustment to the therapy.

COMMUNICATION: Every client is an individual, and it is not possible to determine in advance how your system will react to the supplements you need. It is sometimes necessary to adjust your program as we proceed until your body can begin to properly accept products geared to correct the imbalance. It is your responsibility to do your part by using your nutrition guidelines, exercise your body and mind sufficiently to bring your emotions into a positive balance, eat a proper diet, get plenty of rest, and learn about nutrition. You must stay in contact with the Nutritional Therapist so we can let you know what is happening and the best course of action.

You should request your other healthcare provider, if any, to feel free to contact the Nutritional Therapist for answers to any questions they may have regarding nutritional therapy.

LICENSURE. A Nutritional Therapist is not licensed or certified by any state. However, a Nutritional Therapy Practitioner™ is trained by the Nutritional Therapy Association, Inc.® which provides a certificate of

completion to students who have successfully met all course requirements, including a written and practical exam. A license to practice Nutritional Therapy is not required in some states. Laws and regulations regarding certification and licensure requirements differ from state to state.

By my/our signature(s) below, I/we confirm that I/we have read and fully understand the above disclaimer, are in complete agreement thereto and do freely and without duress sign and consent to all terms contained herein.

NAME (PLEASE PRINT) _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE (HOME) _____ (WORK) _____ (OTHER) _____

SIGNATURE _____ DATE _____

SIGNATURE FOR CLIENT _____

RELATIONSHIP TO CLIENT _____ DATE _____

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NUTRITIONAL THERAPY MAY NOT BE COVERED BY INSURANCE AND ALL COSTS ARE THE SOLE RESPONSIBILITY OF THE CLIENT.