Initial Consultation: Comprehensive Health & Nutrition Intake Form

Consultation Date:

ROOT & BRANCH NUTRITION

Please complete the following in **as much detail as possible** prior to your initial consultation.

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

Today's Date: _____ Name: _____

E-mail address: _____ Phone number: _____ ¨ Home ¨ Cell

Street Address: _____ City: _____ State: _____ Zip: _____

Gender: __ Male __ Female Date of Birth: _____/_____/_____ Place of Birth: _____

Age: _____ Height: _____ Weight: _____ Would you like your weight to be different? Yes / No If so, what? _____

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

Relationship status: _____ Children? _____

Goals and Concerns:

What are your primary issues/top concern(s)? (Why are you seeking nutritional therapy?)

1. _____
2. _____
3. _____
4. _____
5. _____

When did these concerns/issues you're experiencing first occur? _____

_____

How have you dealt with these concerns in the past? _____

_____

Describe your relationship with your weight/history of weight loss/dieting:

_____

_____

What do you feel is hindering you from reaching your goals? (i.e. Lack of knowledge, confusion/overwhelm, lack of support, energy, time, stress, etc.) _____

_____

What would you like to accomplish/gain from working together? _____

_____

Lifestyle:

What do your mornings look like (after waking, before breakfast, breakfast, commute, etc.)? _____

_____

What do your evenings look like (dinner, after dinner, pre-bed, etc.)? _____

_____

Describe your work environment: _____

_____

How many hours per day are you sitting? _____ How often do you spend time in nature? _____

What are your hobbies? _____

What role does exercise play in your life? _____

What type of exercise do you do? _____Duration & frequency? _____

Do you drink alcohol? _____ If so, how much and how often? _____

Do you smoke? _____ If so, how much and how often? _____ If you quit, how and when? _____

Have you explored more natural options for beauty, personal care, and cleaning products? If so, explain. If not, why not?

_____

_____

Sleep & Stress:

How do you sleep? _____ Do you wake up during the night? _____ If so, what time? _____

What time do you go to bed? _____ What time do you wake up? _____

Do you fall asleep easily? _____ How do you feel when you wake up? _____

How would you describe your stress levels? _____

What contributes the most stress to your life? Examples below: **(Circle any + list others below)**

- Physiological: Lack of sleep, chronic infection, digestive issues, dehydration, allergies (food or environmental), nutrient deficiency, blood sugar dysregulation, skin issues, immune challenges, autoimmunity, decreased cognitive function ("brain fog"), etc.
- Physical: Injury, chronic pain, surgeries, chronic inflammation, using caffeine and sugar as stimulants, etc.
- Environmental: Food additives, pesticides, pollution, chemicals in home (such as cleaning and personal care products), sugar, chlorine, fluoride in tap water, vaccines, EMF (electromagnetic fields), etc.
- Emotional: Financial, work/school, relationship, anxiety/worry, depression, regular traffic/commute, repetitive thinking, feeling in position of powerlessness, perfectionism, constant comparison to others, etc.

_____

_____

Do you practice stress-management? _____ If so, how? How often? _____

Health History:

Describe (to the best of your knowledge) your history of antibiotic use: _____

_____

Were you delivered vaginally or via cesarean section? _____

Are you currently taking any vitamins/minerals, herbs/homeopathic remedies, prescription medications, non-prescription medications, aspirin, laxatives, diet pills, or any other supplements? If so, list all, including name brands and amounts if known, below: **(Please list on separate paper if you need more space.)**

_____

_____

_____

Do you have any allergies to herbs or medications? **If so, list all:** _____

_____

Have you been diagnosed with a specific health issue? _____ If so, are you currently under a practitioner's care? _____

If so, what treatments are you undergoing? _____

_____

List any major dental work (surgeries, fillings- especially mercury amalgams) and date: _____

_____

List surgeries, accidents, injuries, hospitalizations, or severe childhood illnesses you have had, along with the type and date:

_____

_____

Nutrition:

Briefly describe your current approach to nutrition/your eating habits (i.e. paleo, gluten-free, low-carb, vegan, clean-eating, calorie-counting, flexible dieting, etc.): _____

_____

How do you eat? Describe your mealtime circumstances (rushed, relaxed, distracted, home, seated, in the car, in class, etc.) _____

_____

Are there any foods you avoid? If so, for what reason(s)? _____

_____

What percentage of your current food intake is home cooked? _____How often do you eat out? _____

What do you believe are the 3 least healthy foods you eat each week? _____

What do you believe are the 3 healthiest foods you eat each week? _____

Do you have food cravings? If so describe: _____

_____

_____

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

How much water do you drink each day (estimate ounces or glasses)? _____

Do you drink coffee or other caffeinated drinks (soda, energy drinks)? ____If so, how much and how often? _____

Digestion/Elimination:

Bowel movement frequency: __ Less than 2x/week/ __ Every other day/ __ 1x/day /__ 2x/day/ __ More than 2x/day

Bowel movement consistency: __ Soft & well-formed/ __ Often float/ __ Difficult to pass/ __ Diarrhea/ __ Thin, long or narrow/ __ Small and hard/ __ Loose and watery/ __ Alternating between hard and loose

Bowel movement color: __ Medium brown/ __ Very dark brown or black/ __ Greenish/ __ Blood is visible/ __ Mucus is visible/ __ Yellow, light brown/ __ Variable/ __ Greasy/shiny

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

_____

Do you experience constipation, diarrhea, gas, or other digestive distress often? (Describe type, how often, and when):

_____

_____

Family Health History:

	Yes/No:	Type (if applicable):	Relation to you:
Autoimmune disease			
Heart Disease			
Digestive disorders			
Kidney disease			
Gallbladder disease			
Cancer			
Thyroid/hormone disorder			
Diabetes			

Women only:

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

Do you track your cycles? Yes / No If so, how? _____

How many days is your flow? _____ Oral contraceptives? No ____ Yes, currently____ Yes, in past____

Non-hormonal contraceptives? (copper IUD, etc.) No ____ Yes, currently____ Yes, in past____

Do you experience PMS? _____ Painful periods/menstrual cramps? _____ Other symptoms? (Please list):

_____

Number of pregnancies: _____ Did you have any problems with conception or pregnancy? _____

_____

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

_____

Were there any complications associated with these births? _____

_____

Did you receive antibiotics during labor? _____

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

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

List any symptoms of peri/menopause: _____

_____

_____

Other:

Do you think family and friends will be supportive of you making health and lifestyle changes to improve your quality of life?

If so, Who? Explain: _____

_____

_____

Please describe any other information you think would be useful in helping to address your health concern(s):

_____

_____

_____

Food Journal: Day 1

Date: _____

Please write down everything you eat (including any supplements) and drink for three (3) consecutive days (try to include at least 1 weekend day). **Please include approximate amounts.** If you notice any digestive, mood, emotional, or energy changes (positive or negative) associated with a meal/snack, record them in the right-hand column. Lastly, please record the time, duration, and type of any exercise completed that day.

Be as detailed (amounts, quality, preparation, times, symptoms, etc.) and honest as you can—the more information provided, the better! There is no judgment—this food journal is used for informational purposes only.

Food	Beverages	Digestion, Mood, Emotional, or Energy Changes
Breakfast: Time: _____	Time: _____	Time: _____
Snack: Time: _____	Time: _____	Time: _____
Lunch: Time: _____	Time: _____	Time: _____
Snack: Time: _____	Time: _____	Time: _____
Dinner: Time: _____	Time: _____	Time: _____
Snack: Time: _____	Time: _____	Time: _____
Medications/Nutritional Supplements: (specify times)		

Exercise: (Time, type, duration, etc.):

_____

_____

Food Journal: Day 2

Date: _____

Please write down everything you eat (including any supplements) and drink for three (3) consecutive days (try to include at least 1 weekend day). **Please include approximate amounts.** If you notice any digestive, mood, emotional, or energy changes (positive or negative) associated with a meal/snack, record them in the right-hand column. Lastly, please record the time, duration, and type of any exercise completed that day.

Be as detailed (amounts, quality, preparation, times, symptoms, etc.) and honest as you can—the more information provided, the better! There is no judgment—this food journal is used for informational purposes only.

Food	Beverages	Digestion, Mood, Emotional, or Energy Changes
Breakfast: Time: _____	Time: _____	Time: _____
Snack: Time: _____	Time: _____	Time: _____
Lunch: Time: _____	Time: _____	Time: _____
Snack: Time: _____	Time: _____	Time: _____
Dinner: Time: _____	Time: _____	Time: _____
Snack: Time: _____	Time: _____	Time: _____
Medications/Nutritional Supplements: (specify times)		

Exercise: (Time, type, duration, etc.):

_____

_____

Food Journal: Day 3

Date: _____

Please write down everything you eat (including any supplements) and drink for three (3) consecutive days (try to include at least 1 weekend day). **Please include approximate amounts.** If you notice any digestive, mood, emotional, or energy changes (positive or negative) associated with a meal/snack, record them in the right-hand column. Lastly, please record the time, duration, and type of any exercise completed that day.

Be as detailed (amounts, quality, preparation, times, symptoms, etc.) and honest as you can—the more information provided, the better! There is no judgment—this food journal is used for informational purposes only.

Food	Beverages	Digestion, Mood, Emotional, or Energy Changes
Breakfast: Time: _____	Time: _____	Time: _____
Snack: Time: _____	Time: _____	Time: _____
Lunch: Time: _____	Time: _____	Time: _____
Snack: Time: _____	Time: _____	Time: _____
Dinner: Time: _____	Time: _____	Time: _____
Snack: Time: _____	Time: _____	Time: _____
Medications/Nutritional Supplements: (specify times)		

Exercise: (Time, type, duration, etc.):

_____

_____

NUTRITIONAL THERAPY INFORMED CONSENT AND DISCLAIMER

Kim Jordan, Nutritional Therapy Practitioner, Root and Branch Nutrition

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

GOAL: My 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.***

I, as a Nutritional Therapy Practitioner (NTP), am trained to evaluate your nutritional needs and make recommendations of dietary change and nutritional supplements. A Nutritional Therapy Practitioner is *not trained to provide medical diagnoses, and no comment or recommendation should be construed as being a medical diagnosis.* Especially since every human being is unique, I 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 Therapy Practitioner is not a substitute for your family physician or other appropriate healthcare provider*. *I am not trained nor licensed to diagnose or treat pathological conditions, illnesses, injuries, or diseases, nor will I attempt to diagnose, treat, or cure any medical condition.*

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 as well as nutrition and lifestyle changes. Nutritional therapy may be a beneficial adjunct to more traditional care, and it may also alter your need for medication and other therapies, 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 me 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 or supplements, *discontinue their use immediately, and contact me* 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 any supplements and nutrition changes. It is *sometimes necessary to adjust your program as we proceed* until your body can begin to properly accept foods and supplements geared to correct any imbalances.

It is your responsibility *to do your part by using your nutrition guidelines, exercising your body and mind sufficiently to bring your emotions into a positive balance, eating a proper diet, getting plenty of rest, and learning*

about nutrition. You must stay in contact with me so that I can know what is happening and the best course of action.

I recommend that you request your other healthcare provider(s), if any, to feel free to contact me for answers to any questions they may have regarding nutritional therapy.

LICENSURE. A Nutritional Therapist is *not licensed or certified by any state.* 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.

SERVICES PROVIDED BY NUTRITIONAL THERAPY PRACTITIONERS ARE NOT COVERED BY INSURANCE AND ALL COSTS ARE THE SOLE RESPONSIBILITY OF THE CLIENT.

Please be aware: There is a **24 hour cancellation policy** as common courtesy to the practice and other clients. If you need to cancel or reschedule an appointment, you must do so within 24 hours of your scheduled start time (via phone or e-mail). **Failure to do so will result in a $50 cancellation fee.**

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 _____

IF UNDER 18 YEARS OLD:

SIGNATURE FOR CLIENT _____

RELATIONSHIP TO CLIENT _____ DATE _____